MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. HEALTH FINANCIAL SYSTEMS

IN LIEU OF FORM CMS-2552-96(04/2005) PREPARED 11/17/2008 8
FORM APPROVED

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)). FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS (42 USC 1395g).

WORKSHEET S PARTS I & II

OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH	I	PROVIDER NO:	I PERIOD	I INTERMEDIARY USE ONLY	I	DATE RECEIVED:
CARE COMPLEX	I	15-2018	I FROM 7/ 1/2007	IAUDITEDDESK REVIEW	I	/ /
COST REPORT CERTIFICATION	I		I TO 6/30/2008	IINITIALREOPENED	I	INTERMEDIARY NO:
AND SETTLEMENT SUMMARY	I		I	IFINAL 1-MCR CODE	I	
				<pre>I 00 - # OF REOPENINGS</pre>	I	
		ELECTRONICALLY	FILED COST REPORT	DATE: 11/17/2008	TIME	8:55

PART I - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISIONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
OUR LADY OF PEACE HOSPITAL, INC. 15-2018

OUR LADY OF PEACE HOSPITAL, INC.

FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2007 AND ENDING 6/30/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

> OFFICER OR ADMINISTRATOR OF PROVIDER(S) TITLE DATE

	P.F	ART II - SE	TTLEMENT SUMMARY		
	TITLE		TITLE	TITLE	
	v		XVIII	XIX	
		A	В		
	1	2	3	4	
AL		0	93,554	0	0
		^	02 554	0	0

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

MCRS/PC-WIN 2552-96 version 1701.000100 - Interface version 264.000100

2552-96 v1701.100

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HEALTH FINANCIAL SYSTEMS
                                       MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC.
                                                                                                                  IN LIEU OF FORM CMS-2552-96 (05/2007)
                                                                                                                        I PERIOD: I PREPARED 11/17/2008
I FROM 7/ 1/2007 I WORKSHEET S-2
                                                                                                   PROVIDER NO:
 HOSPITAL & HOSPITAL HEALTH CARE COMPLEX
                                                                                                   15-2018
          IDENTIFICATION DATA
                                                                                                                         т то
                                                                                                                                   6/30/2008 I
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS
     1 STREET: 801 EAST LASALLE AVE, 4TH FLOOR
                                                                          P.O. BOX:
                                                                                                                       COUNTY: SAINT JOSEPH
 1 01 CTTY:
                     SOUTH BEND
                                                                         STATE: IN
                                                                                          ZTP CODE: 46617-
HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;
                                                                                                                                                         PAYMENT SYSTEM
                                                                                                                                                         (P, T, O OR N)
                                                                                                                                         DATE
            COMPONENT
                                                     COMPONENT NAME
                                                                                                PROVIDER NO.
                                                                                                                    NPI NUMBER
                                                                                                                                      CERTIFIED
                                                                                                                                                         v xviii xix
                                                                                                                                       8/ 4/2000
02.00 HOSPITAL
                                               OUR LADY OF PEACE HOSPITAL. INC.
                                                                                                   15-2018
                                                             FROM: 7/ 1/2007
17
         COST REPORTING PERIOD (MM/DD/YYYY)
                                                                                                  TO: 6/30/2008
         TYPE OF CONTROL
TYPE OF HOSPITAL/SUBPROVIDER
                                                                                                                                      2
         HOSPITAL
20
         SUBPROVIDER
         INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORT PERIOD
         IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS
         YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.
         DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE
         SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106?
         HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSICATION STATUS CHANGE AFTER THE FIRST DAY
         OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
         ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN OR (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION
         TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, EN IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN
         100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN
         COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.
         FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE
21.04
        BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN OR (2) RURAL FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE
                                                                                                                                      1
        END OF THE COST REPORTING PERIOD. ENTER (1) URBAN OR (2) RURAL
DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS
21.06
         FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL
         OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER "Y" FOR YES, AND "N" FOR NO
         ARE YOU CLASSIFIED AS A REFERRAL CENTER?
                                                                                                                                      N
         DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE.
23.01
         IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE.
23.03
         IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION DATE
23 05
         IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER. ENTER THE CERTIFICATION DATE.
23.06
         IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE.
         IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO). ENTER THE OPO NUMBER IN COLUMN 2.
24
         IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING
         PAYMENTS FOR TAR?
                                                                                                                                      N
         IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?
                                                                                                                                      N
         IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN
         EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET
         E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.
        AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED
25.03
25.04
25.05
         UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)
                                                                                                                                      N
         HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE
         RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c) (4) OR 42 CFR 412.105(f) (1) (iv) (C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)
         IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01.
26
         SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.

ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDIN
26.01
                                                                                                 / /
                                                                                                                      ENDING:
         ENTER THE APPLICABLE SCH DATES:
                                                                                  BEGINNING:
                                                                                                                      ENDING:
         DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913
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2552-96 v1701.100

FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN LIEU OF FORM CMS-2552-96 (05/2007) CONTD I PROVIDER NO: I 15-2018 I PERIOD: I PREPARED 11/17/2008
I FROM 7/ 1/2007 I WORKSHEET S-2 HOSPITAL & HOSPITAL HEALTH CARE COMPLEX 15-2018 6/30/2008 I IDENTIFICATION DATA T TO IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF. ARE ALL PATIENTS UNDER MANAGED CARE OR 28 THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02

28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. 2 ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS) 0 0 0000 0 0000 28.02 ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE 0.00 0 OR TWO CHARACTER CODE IF RURAL BASED FACILITY
A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN
INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE
USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR) 28 03 STAFFING 0 00% RECRUITMENT 0.00% 28.04 28 05 RETENTION 0 00% TRAINING 28.06 0.00% 29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70 30.01 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF 30.02 PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)

IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST 30.03 BE ON OR AFTER 12/21/2000). IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R 30.04 TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II
IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 31 CFR 412.113(c). N IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 31.01 CFR 412.113(c). N 31.02 IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N 31.03 IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c) N 31.04 IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c) N 31.05 IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N MISCELLANEOUS COST REPORT INFORMATION IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2. IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO N 33 IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f) (1) (i) TEFRA? 35 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N 35.02 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? XVIII XIX PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N Y N DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS)
DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N

37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?

N N

N N

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HEALTH FINANCIAL SYSTEMS
                                            MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC.
                                                                                                                             IN LIEU OF FORM CMS-2552-96 (05/2007) CONTD
                                                                                                             PROVIDER NO:
                                                                                                                                    I PERIOD: I PREPARED 11/17/2008
I FROM 7/ 1/2007 I WORKSHEET S-2
 HOSPITAL & HOSPITAL HEALTH CARE COMPLEX
                                                                                                             15-2018
           IDENTIFICATION DATA
                                                                                                                                     т то
                                                                                                                                                6/30/2008 I
TITLE XIX INPATIENT SERVICES
          DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?
          IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?
                                                                                                                                                   N
          DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?
         ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?
                                                                                                                                                   N
38.03
38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?
                                                                                                                                                   N
         ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10?
         IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COL 2 THE HOME OFFICE PROVIDER NUMBER. IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION ENTER THE NAME AND ADDRESS OF THE HOME OFFICE Y
40.01 NAME: SAINT JOSEPH REGIONAL MEDICAL CENTER FI/CONTRACTOR NAME ADMINISTAR FEDERAL 40.02 STREET: 801 EAST LASALLE P.O. BOX:
                                                                                                                                                                FI/CONTRACTOR #
        CITY: SOUTH BEND STATE: IN ZIP CODE: 46617-ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?
40.03 CITY:
                                                                                                                                                   N
         ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?
42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?
42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?
43
        ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?
         IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY?
        HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.
                                                                                                                                                         00/00/0000
45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?
45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?
45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?
        IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF)
         DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).
IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "Y" FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION. ENTER "N" IF NOT EXEMPT.
(SEE 42 CFR 413.13.)
                                                                       OUTPATIENT
                                                                                        OUTPATIENT
                                                                                                         OUTPATIENT
                                       PART A
                                                         PART B
                                                                                         RADIOLOGY
                                                                           ASC
                                                                                                          DIAGNOSTIC
                                                                              3
                                                                                                4
47.00 HOSPITAL
         DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH
         42 CFR 412.348(e)? (SEE INSTRUCTIONS)
        IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL
         EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN
                                                                                                                                                   N
53
         EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.
                                       MDH PERIOD:
53.01
                                                                                          BEGINNING:
        LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
54
                                          PAID LOSSES:
                                                                                      0
                                AND/OR SELF INSURANCE:
54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND
         GENERAL COST CENTER? IF YES. SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS
         CONTAINED THEREIN.
55
         DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH
        ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS
                                                                                                                                                   N
                                                                                                                                                                                           FEES
                                                                                                                                      DATE
                                                                                                                                                Y OR N
                                                                                                                                                             LIMIT
         IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN
                                                                                                                                                     1
                                                                                                                                        0
                                                                                                                                                                2
                                                                                                                                                                                            4
         2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF
         OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE,
                                                                                                                                                     N
                                                                                                                                                                  0.00
                                                                                                                                                                           N
                                                                                                                                                                                               n
         THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.
        ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2
                                                                                                                                                                  0.00
                                                                                                                                                                                               0
         LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.
56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.
                                                                                                                                                                  0.00
                                                                                                                                                                                               0
                                                                                                                                                                  0.00
         ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?
        ARE YOU AN IMPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS
                                                                                                                                                     N
         ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE
         10/1/2002.
58.01 IF LINE 58 COLUMN 1 IS Y. DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST
                                                                                                                                                                          0
         REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC.
         412.424(d) (1) (iii) (2)? ENTER IN COLUMN 2 "Y"FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER
         1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS
        OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).

ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO.

IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2
59
         "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)
ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER?
                                                                                                                                                     Y
         ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)
                                                                                                                                                     N
                                                                                                                                                                N
FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)

60.01 IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y"FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).
                                                                                                                                                                           ი
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HEAL	тн	FINANCIAL SYSTEMS MCRS/PG	C-WIN FOR OU	R LADY OF PEACE		, INC. IN PROVIDER NO:			(04/2005) REPARED 11/17/2008
		HOSPITAL AND HOSPITAL H	HEALTH CARE			15-2018			WORKSHEET S-3
		COMPLEX STATISTICAL	DATA		Ī			/30/2008 I	
									TRIPS
				BED DAYS	CAH	TITLE	TITLE	NON COVERED	TOTAL
		COMPONENT	BEDS	AVAILABLE	N/A	V	XVIII		
			1	2	2.01	3	4	4.01	5
1		ADULTS & PEDIATRICS	32	11,712			5,88		
2		HMO					1,73	5	
2	01	HMO - (IRF PPS SUBPROVIDER)							
3		ADULTS & PED-SB SNF							
4		ADULTS & PED-SB NF							
5		TOTAL ADULTS AND PEDS	32	11,712			5,88	9	
12		TOTAL	32	11,712			5,88	9	
13		RPCH VISITS							
16		NURSING FACILITY							
25		TOTAL	32						
26		OBSERVATION BED DAYS							
27		AMBULANCE TRIPS							
28		EMPLOYEE DISCOUNT DAYS							
28	01	EMP DISCOUNT DAYS -IRF							
				I/P DAYS /	O/P VISIT	S / TRIPS -		INTERNS	& RES. FTES

	COMPONENT	TITLE XIX OB ADMITTED 5.01	I/P DAYS / SERVATION BEDS NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	•	ERVATION BEDS NOT ADMITTED 6.02	INTERNS TOTAL 7	& RES. FTES LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			8,597				
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS			8,597				
12	TOTAL			8,597				
13	RPCH VISITS							
16	NURSING FACILITY							
25	TOTAL							
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							

	COMPONENT	I & R FTES	FULL TIME EMPLOYEES ON PAYROLL	EQUIV NONPAID WORKERS	TITLE V	DISCHARGES TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS
		9	10	11	12	13	14	15
1	ADULTS & PEDIATRICS					222		318
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
12	TOTAL		57.16			222		318
13	RPCH VISITS							
16	NURSING FACILITY							
25	TOTAL		57.16					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN LIEU OF FORM CMS-2552-96 (05/2004)

I PROVIDER NO: I PERIOD: I PREPARED 11/17/2008

HOSPITAL WAGE INDEX INFORMATION I 15-2018 I FROM 7/ 1/2007 I WORKSHEET S-3

I TO 6/30/2008 I PARTS II & III

PART II	- WAGE DATA	AMOUNT REPORTED 1	RECLASS OF SALARIES 2	ADJUSTED SALARIES 3	PAID HOURS RELATED TO SALARY 4	AVERAGE HOURLY WAGE 5	DATA SOURCE
	SALARIES						
1	TOTAL SALARY	3,254,055		3,254,055	118,890.00	27.37	
2	NON-PHYSICIAN ANESTHETIST						
3	PART A NON-PHYSICIAN ANESTHETIST						
4	PART B PHYSICIAN - PART A						
_	TEACHING PHYSICIAN SALARIES						
5	(SEE INSTRUCTIONS)						
-	PHYSICIAN - PART B NON-PHYSICIAN - PART B						
6	INTERNS & RESIDENTS (APPRVD)						
6.01 7	CONTRACT SERVICES, I&R HOME OFFICE PERSONNEL						
8	SNF						
8.01	EXCLUDED AREA SALARIES						
•	OTHER WAGES & RELATED COSTS						
9 9.01	CONTRACT LABOR: PHARMACY SERVICES UNDER						
	CONTRACT						
9.02	LABORATORY SERVICES UNDER CONTRACT						
9.03	MANAGEMENT & ADMINISTRATIVE						
10	UNDER CONTACT						
10 10.01	CONTRACT LABOR: PHYS PART A TEACHING PHYSICIAN UNDER						
	CONTRACT (SEE INSTRUCTIONS)						
11	HOME OFFICE SALARIES & WAGE RELATED COSTS						
12	HOME OFFICE: PHYS PART A						
12.01	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
10	WAGE RELATED COSTS	004 400		004 400		_	wa 220
13 14	WAGE-RELATED COSTS (CORE) WAGE-RELATED COSTS (OTHER)	904,499		904,499			MS 339 MS 339
15	EXCLUDED AREAS						MS 339
16 17	NON-PHYS ANESTHETIST PART A NON-PHYS ANESTHETIST PART B						MS 339 MS 339
18	PHYSICIAN PART A						MS 339
18.01 19	PART A TEACHING PHYSICIANS						MS 339 MS 339
	PHYSICIAN PART B WAGE-RELATD COSTS (RHC/FQHC)						CMS 339
20	INTERNS & RESIDENTS (APPRVD)					C	MS 339
	OVERHEAD COSTS - DIRECT SALARIES						
21	EMPLOYEE BENEFITS	450 527		450 527	1,440.75	E2 0E	
22 22.01	ADMINISTRATIVE & GENERAL A & G UNDER CONTRACT	450,537		450,537	8,508.75	52.95	
23	MAINTENANCE & REPAIRS						
24 25	OPERATION OF PLANT LAUNDRY & LINEN SERVICE						
26	HOUSEKEEPING						
	HOUSEKEEPING UNDER CONTRACT						
27 27.01	DIETARY DIETARY UNDER CONTRACT						
28	CAFETERIA						
29 30	MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION	127,703		127,703	4,200.00	30.41	
31	CENTRAL SERVICE AND SUPPLY						
32 33	PHARMACY MEDICAL RECORDS & MEDICAL	278,147 34,716		278,147 34,716	6,913.92 2,015.50	40.23 17.22	
	RECORDS LIBRARY	54,710		34,710	2,013.30	17.22	
34 35	SOCIAL SERVICE OTHER GENERAL SERVICE						
	- HOSPITAL WAGE INDEX SUMMARY						
1	NET SALARIES	3,254,055		3,254,055	118,890.00	27.37	
2	EXCLUDED AREA SALARIES				,		
3 4	SUBTOTAL SALARIES SUBTOTAL OTHER WAGES &	3,254,055		3,254,055	118,890.00	27.37	
5	RELATED COSTS SUBTOTAL WAGE-RELATED COSTS	904,499		904,499		27.80	
6	TOTAL WAGE-RELATED COSTS	4,158,554		4,158,554	118,890.00	34.98	
7	NET SALARIES			•			
8 9	EXCLUDED AREA SALARIES SUBTOTAL SALARIES						
10	SUBTOTAL OTHER WAGES &						
11	RELATED COSTS SUBTOTAL WAGE-RELATED COSTS						
12	TOTAL						

13 TOTAL OVERHEAD COSTS 891,103 891,103 23,078.92 38.61

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN LIEU OF FORM CMS-2552-96 S-10 (05/2004)

I PROVIDER NO: I PERIOD: I PROPRIOD: I PROPR

## DESCRIPTION

	DESCRIPTION	
1	UNCOMPENSATED CARE INFORMATION DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER	
0.01	LINES 2.01 THRU 2.04	
2.01		
	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	
2.04		
3 4	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS? ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE	
	JUDGMENT WITHOUT FINANCIAL DATA?	
	ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY? ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS)	
•	DATA?	
7	ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET	
8	WORTH DATA? DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD	
ū	DEBT AND CHARITY CARE? IF YES ANSWER 8.01	
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN	
	YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	
9.02		
0.00	CHARITY FROM BAD DEBT?	
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	
9.04		
10	DISTINCTION IMPORTANT?  IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA,	
10	WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS	
	(SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO	
11	BE A CHARITY WRITE OFF? IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA,	
	IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY	
11.01	LEVEL? IF YES ANSWER 11.01 THRU 11.04 IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL	
11.01	POVERTY LEVEL?	
11.02		
11.03	OF THE FEDERAL POVERTY LEVEL? IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200%	
	OF THE FEDERAL POVERTY LEVEL?	
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME	
	PATIENTS ON A GRADUAL SCALE?	
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY	
	MEDICAL EXPENSES?	
14	IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02	
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT	
	GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING	
14.02	COMPENSATED CARE? WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM	
	GOVERNMENT FUNDING?	
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE	
	CHARITY CARE?	
17	UNCOMPENSATED CARE REVENUES REVENUE FROM UNCOMPENSATED CARE	20,899
	GROSS MEDICAID REVENUES	20,033
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	
19 20	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS) RESTRICTED GRANTS	
	NON-RESTRICTED GRANTS	
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES UNCOMPENSATED CARE COST	20,899
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL	
24	INDIGENT CARE PROGRAMS	074405
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103)	. 374405
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST	
26	(LINE 23 * LINE 24) TOTAL SCHIP CHARGES FROM YOUR RECORDS	
27	TOTAL SCHIP CHARGES FROM TOOK RECORDS  TOTAL SCHIP COST, (LINE 24 * LINE 26)	
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	
29 30	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28) OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	
	The state of the state o	

- UNCOMPENSATED CARE COST (LINE 24 \* LINE 30) TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29) 31 32

MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN LIEU OF FORM CMS-2552-96(9/1996)

I PROVIDER NO: I PERIOD: I PREPARED 11/17/2008

ADJUSTMENT OF I 15-2018 I FROM 7/ 1/2007 I WORKSHEET A
EXPENSES I I TO 6/30/2008 I HEALTH FINANCIAL SYSTEMS

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

	COST		SALARIES	OTHER	TOTAL	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANC
	CLITI		1	2	3	4	5
		GENERAL SERVICE COST CNTR					
1	0100	OLD CAP REL COSTS-BLDG & FIXT					
2	0200	OLD CAP REL COSTS-MVBLE EQUIP					
3	0300	NEW CAP REL COSTS-BLDG & FIXT				466,148	466,148
4	0400	NEW CAP REL COSTS-MVBLE EQUIP				193,559	193,559
5	0500	EMPLOYEE BENEFITS		904,499	904,499		904,499
6	0600	ADMINISTRATIVE & GENERAL	450,537	2,099,102	2,549,639	-659,707	1,889,932
9	0900	LAUNDRY & LINEN SERVICE		87,759	87,759		87,759
11	1100	DIETARY		103,055	103,055		103,055
14	1400	NURSING ADMINISTRATION	127,703	122	127,825		127,825
16	1600	PHARMACY	278,147	885,881	1,164,028	-896,692	267,336
17	1700	MEDICAL RECORDS & LIBRARY	34,716	11,934	46,650		46,650
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	2,362,952	180,453	2,543,405		2,543,405
35	3500	NURSING FACILITY					
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM		357,978	357,978		357,978
41	4100	RADIOLOGY-DIAGNOSTIC		321,688	321,688		321,688
42	4200	RADIOLOGY-THERAPEUTIC		45,923	45,923		45,923
44	4400	LABORATORY		241,197	241,197		241,197
46	4600	WHOLE BLOOD & PACKED RED BLOOD CELLS		32,343	32,343		32,343
48	4800	INTRAVENOUS THERAPY					
49	4900	RESPIRATORY THERAPY		504,816	504,816		504,816
50	5000	PHYSICAL THERAPY		305,583	305,583		305,583
51	5100	OCCUPATIONAL THERAPY		82,517	82,517		82,517
52	5200	SPEECH PATHOLOGY		116,160	116,160		116,160
53	5300	ELECTROCARDIOLOGY		10,742	10,742		10,742
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		321,591	321,591	-1,737	319,854
56	5600	DRUGS CHARGED TO PATIENTS				898,429	898,429
57	5700	RENAL DIALYSIS		366,221	366,221		366,221
		OUTPAT SERVICE COST CNTRS					
61	6100	EMERGENCY					
		SPEC PURPOSE COST CENTERS					
88	8800	INTEREST EXPENSE					
95		SUBTOTALS	3,254,055	6,979,564	10,233,619	-0-	10,233,619
		NONREIMBURS COST CENTERS					•
.01.		TOTAL	3,254,055	6,979,564	10,233,619	-0-	10,233,619

MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN LIEU OF FORM CMS-2552-96(9/1996)

I PROVIDER NO: I PERIOD: I PREPARED 11/17/2008

ADJUSTMENT OF I 15-2018 I FROM 7/ 1/2007 I WORKSHEET A
EXPENSES I I TO 6/30/2008 I HEALTH FINANCIAL SYSTEMS

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

	COST	COST CENTER DESCRIPTION	AD.TIISTMENTS	NET EXPENSES
	CENTE		ADOUGHERIS	FOR ALLOC
	021112	<del></del>	6	7
		GENERAL SERVICE COST CNTR	·	•
1	0100	OLD CAP REL COSTS-BLDG & FIXT		
2		OLD CAP REL COSTS-MVBLE EQUIP		
3		NEW CAP REL COSTS-BLDG & FIXT	_1 977	464,271
4		NEW CAP REL COSTS-BUDG & FIXT	92,316 290,741	103,271
5		EMPLOYEE BENEFITS	92 316	996 915
6		ADMINISTRATIVE & GENERAL	200 741	2 100 672
9		LAUNDRY & LINEN SERVICE	230,741	87,759
11		DIETARY		103.055
14		NURSING ADMINISTRATION		103,035
16		PHARMACY		267,336
17	1700	MEDICAL RECORDS & LIBRARY		46,650
		INPAT ROUTINE SRVC CNTRS		
25		ADULTS & PEDIATRICS		2,543,405
35	3500	NURSING FACILITY		
		ANCILLARY SRVC COST CNTRS		
37		OPERATING ROOM		357,978
41		RADIOLOGY-DIAGNOSTIC		321,688
42		RADIOLOGY-THERAPEUTIC		45,923
44		LABORATORY		241,197
46		WHOLE BLOOD & PACKED RED BLOOD CELLS		32,343
48		INTRAVENOUS THERAPY		
	4900	RESPIRATORY THERAPY		504,816
		PHYSICAL THERAPY		305,583
51	5100	OCCUPATIONAL THERAPY		82,517
52	5200	SPEECH PATHOLOGY		116,160
53	5300	ELECTROCARDIOLOGY		10,742
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		319,854
56	5600	DRUGS CHARGED TO PATIENTS		898,429
57	5700	RENAL DIALYSIS		366,221
		OUTPAT SERVICE COST CNTRS		
61	6100	EMERGENCY		
		SPEC PURPOSE COST CENTERS		
88	8800	INTEREST EXPENSE		-0-
95		SUBTOTALS	381,180	10,614,799
		NONREIMBURS COST CENTERS	/=	-,- ,
101.		TOTAL		10,614,799

HEALTH FINANCIAL SYSTEMS	MCRS/PC-WIN	FOR OUR LADY OF PEACE	HOSPITAL, INC.	IN LIEU OF FOR	M CMS-2552-96(9/1996)
			I PROVIDER NO:	I PERIOD:	I PREPARED 11/17/2008
COST CENTERS USED	IN COST REPORT		I 15-2018	I FROM 7/ 1/2007	I NOT A CMS WORKSHEET
			I	I TO 6/30/2008	I

LINE NO. COST CENTER DESCRIPTION CMS CODE STANDARD LABEL FOR NON-STANDARD CODES GENERAL SERVICE COST OLD CAP REL COSTS-BLDG & FIXT
OLD CAP REL COSTS-MVBLE EQUIP
NEW CAP REL COSTS-BLDG & FIXT 0100 0200 0300 NEW CAP REL COSTS-MVBLE EQUIP 0400 0500 EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL LAUNDRY & LINEN SERVICE DIETARY 0600 0900 11 1100 14 16 17 NURSING ADMINISTRATION PHARMACY 1400 1600 MEDICAL RECORDS & LIBRARY
INPAT ROUTINE SRVC C
ADULTS & PEDIATRICS 1700 2500 NURSING FACILITY ANCILLARY SRVC COST 35 3500 3700 4100 37 41 42 44 46 48 49 50 51 52 53 55 56 57 OPERATING ROOM
RADIOLOGY-DIAGNOSTIC RADIOLOGY-THERAPEUTIC 4200 LABORATORY 4400 4600 WHOLE BLOOD & PACKED RED BLOOD CELLS INTRAVENOUS THERAPY RESPIRATORY THERAPY 4800 4900 PHYSICAL THERAPY OCCUPATIONAL THERAPY 5000 5100 SPEECH PATHOLOGY ELECTROCARDIOLOGY 5200 5300 MEDICAL SUPPLIES CHARGED TO PATIENTS 5500 DRUGS CHARGED TO PATIENTS RENAL DIALYSIS 5600 5700 OUTPAT SERVICE COST EMERGENCY 61 6100 SPEC PURPOSE COST CE INTEREST EXPENSE 8800 88 95 SUBTOTALS 0000 NONREIMBURS COST CEN TOTAL 0000 101.

HEALTH FINANCIAL SYSTEMS	MCRS/PC-WIN	FOR OUR LADY OF PEACE HO	SPITAL, INC.	IN LIEU	OF FORM CMS-2552-96 (09/1996)
			PROVIDER NO:	PERIOR	):   PREPARED 11/17/2008
RECLASSIFICATIONS			152018	FROM	7/ 1/2007   WORKSHEET A-6
			1	TO	6/30/2008

EXPLANATION OF RECLASSIFICATION	CODE (1)		INCREASE LINE NO 3	SALARY OTHER 4 5
1 DRUG RECLASS - PHARMACY	A	DRUGS CHARGED TO PATIENTS	56	896,692
2 DRUG RECLASS - MED SUPP	В	DRUGS CHARGED TO PATIENTS	56	1,737
3 BUILDING LEASE RECLASS	С	NEW CAP REL COSTS-BLDG & FIXT	3	462,135
4 EQUIPMENT LEASE RECLASS - A&G	D	NEW CAP REL COSTS-MVBLE EQUIP	4	29,210
5 EQUIPMENT LEASE RECLASS - MED SU	P E	NEW CAP REL COSTS-MVBLE EQUIP	4	104,447
6 EQUIPMENT REPAIRS RECLASS	F	NEW CAP REL COSTS-BLDG & FIXT	3	139
7 INSURANCE RECLASS	G	NEW CAP REL COSTS-BLDG & FIXT	3	3,874
8 DEPRECIATION RECLASS	Н	NEW CAP REL COSTS-MVBLE EQUIP	4	59,902
36 TOTAL RECLASSIFICATIONS				1,558,136

<sup>(1)</sup> A letter (A, B, etc) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

HEALTH FINANCIAL SYSTEMS	MCRS/PC-WIN	FOR OUR LADY OF PEACE HOSPITAL, INC.	IN LIEU OF FORM CMS-2552-96 (09/1996)
		PROVIDER NO	:   PERIOD:   PREPARED 11/17/2008
RECLASSIFICATIONS		152018	FROM 7/ 1/2007   WORKSHEET A-6
		1	I TO 6/30/2008 I

			2201121102			
	CODE		LINE			A-7
EXPLANATION OF RECLASSIFICATION	(1)	COST CENTER	NO	SALARY	OTHER	REF
	1	6	7	8	9	10
1 DRUG RECLASS - PHARMACY	A	PHARMACY	16		896,692	
2 DRUG RECLASS - MED SUPP	В	MEDICAL SUPPLIES CHARGED TO PA	ATIENTS 55		1,737	
3 BUILDING LEASE RECLASS	С	ADMINISTRATIVE & GENERAL	6		462,135	10
4 EQUIPMENT LEASE RECLASS - A&G	D	ADMINISTRATIVE & GENERAL	6		29,210	14
5 EQUIPMENT LEASE RECLASS - MED SUPP	E	ADMINISTRATIVE & GENERAL	6		104,447	14
6 EQUIPMENT REPAIRS RECLASS	F	ADMINISTRATIVE & GENERAL	6		139	14
7 INSURANCE RECLASS	G	ADMINISTRATIVE & GENERAL	6		3,874	12
8 DEPRECIATION RECLASS	H	ADMINISTRATIVE & GENERAL	6		59,902	9
36 TOTAL RECLASSIFICATIONS					1,558,136	

<sup>(1)</sup> A letter (A, B, etc) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC.

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL
ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS

1 15-2018
1 17 10 6/30/2008
1 PROM 7/ 1/2007
1 WORKSHEET A-7
1 PARTS I & II

# PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION				ACQUISITIONS		DISPOSALS		FULLY	
	BEGIN					AND	ENDING	DEPRECIATED	
		BALANCES	PURCHASES	DONATION	TOTAL	RETIREMENTS	BALANCE	ASSETS	
		1	2	3	4	5	6	7	
1	LAND								
2	LAND IMPROVEMENTS								
_									

- BUILDINGS & FIXTURE BUILDING IMPROVEMEN
- FIXED EQUIPMENT
  MOVABLE EQUIPMENT

- SUBTOTAL RECONCILING ITEMS

# PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION						DISPOSALS		FULLY
		BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	AND RETIREMENTS	ENDING BALANCE	DEPRECIATED ASSETS
		1	2	3	4	5	6	7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE	43,736					43,736	
4	BUILDING IMPROVEMEN		4,270		4,270		4,270	
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	336,302	137,604		137,604	3,090	470,816	26,084
7	SUBTOTAL	380,038	141,874		141,874	3,090	518,822	26,084
8	RECONCILING ITEMS							
9	TOTAL	380,038	141,874		141,874	3,090	518,822	26,084

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC.

RECONCILIATION OF CAPITAL COSTS CENTERS

I PROVIDER NO:

I 15-2018

I 150 6/30/2008

I WORKSHEET A-7

PARTS III & IV.

D3.D#	TIT DECONOTION OF	CARTERI COCE C	ENWED C						
PART	III - RECONCILIATION OF DESCRIPTION	CAPITAL COST C	COMPUTATION	OF PATTOS		7.1.1	OCATION OF OTH	ובס כאסדייאד	
	DESCRIPTION	GROSS	CAPITLIZED GR			ALL L	OCATION OF OIL	OTHER CAPITAL	
		ASSETS	LEASES	FOR RATIO	RATIO	INSURANCE	TAXES	RELATED COSTS	TOTAL
*		1	2	3	4	5	6	7	8
1	OLD CAP REL COSTS-BL		=	_	=	_	•	·	_
2	OLD CAP REL COSTS-MV								
3	NEW CAP REL COSTS-BL								
4	NEW CAP REL COSTS-MV								
5	TOTAL				1.000000				
	DESCRIPTION			SUMMARY OF C	LD AND NEW CAP	PITAL			
							OTHER CAPITAL	:	
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	RELATED COST	TOTAL (1)	
*		9	10	11	12	13	14	15	
1	OLD CAP REL COSTS-BL								
2	OLD CAP REL COSTS-MV								
3	NEW CAP REL COSTS-BL		460,258		3,874		139	464,271	
4	NEW CAP REL COSTS-MV	59,902					133,657	193,559	
5	TOTAL	59,902	460,258		3,874		133,796	657,830	
рарт	IV - RECONCILIATION OF	AMOUNTS FROM WO	BKSHEET V CC	NT.IIMN 2 T.TNE	S 1 THRII 4				
1711(1	DESCRIPTION	AMOUNID I NOM HO			LD AND NEW CAP	ттат.			
	220011111011						OTHER CAPITAL		
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	RELATED COST		
*		9	10	11	12	13	14	15	
1	OLD CAP REL COSTS-BL	-							
2	OLD CAP REL COSTS-MV								
3	NEW CAP REL COSTS-BL								
4	NEW CAP REL COSTS-MV								
5	TOTAL								
•									

All lines numbers except line 5 are to be consistent with Workheet A line numbers for capital cost centers.

The amounts on lines 1 thru 4 must equal the corresponding amounts on Worksheet A, column 7, lines 1 thru 4.

Columns 9 through 14 should include related Worksheet A-6 reclassifications and Worksheet A-8 adjustments. (See instructions).

MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN LIEU OF FORM CMS-2552-96(05/1999)

I PROVIDER NO: I PERIOD: I PREPARED 11/17/2008

JUSTMENTS TO EXPENSES

I 15-2018
I TO 6/30/2008
I WORKSHEET A-8 HEALTH FINANCIAL SYSTEMS

ADJUSTMENTS TO EXPENSES

				EXPENSE CLASSIFICATION ON		
	DESCRIPTION (1)			WORKSHEET A TO/FROM WHICH T	HE	WKST.
		(2)		AMOUNT IS TO BE ADJUSTED		A-7
		BASIS/CODE	AMOUNT	COST CENTER	LINE NO	REF.
		1	2	3	4	5
1	INVST INCOME-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			OLD CAP REL COSTS-MVBLE E	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5	INVESTMENT INCOME-OTHER					
6	TRADE, QUANTITY AND TIME DISCOUNTS					
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES					
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2				
13	SALE OF SCRAP, WASTE, ETC.	0 -				
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1	551,456			
15	LAUNDRY AND LINEN SERVICE	0 1	552, 155			
16	CAFETERIAEMPLOYEES AND GUESTS					
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS					
21	NURSG SCHOOL (TUITN, FEES, BOOKS, ETC.)					
22	VENDING MACHINES					
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
26	ADJUSTMENT FOR PHISICAL THERAPY ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3 A-8-3		PHISICAL THERAPI	50	
28	UTILIZATION REVIEW-PHYSIAN COMP	A-6-3		**COST CENTER DELETED**	89	
28	DEPRECIATION REVIEW-PHISIAN COMP			OLD CAP REL COSTS-BLDG &	1	
30					2	
31	DEPRECIATION OLD MOVABLE EQUIP			OLD CAP REL COSTS-MVBLE E	3	
	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	-	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		OCCUPATIONAL THERAPY	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
37	MARKETING EXPENSES	A	-93,194		6	
38	BAD DEBT	A	-66,323		6	
39	MISCELLANEOUS INCOME	В	-4,436		6	
40	MISCELLANEOUS RENTAL INCOME	В	-1,877		3	10
41	OTHER EXPENSES	A	-3,091		6	
42	DONATIONS	A	-1,200		6	
43	LOBBING EXPENSES FROM DUES	A	-155	ADMINISTRATIVE & GENERAL	6	
44	OTHER ADJUSTMENTS (SPECIFY)					
45	OTHER ADJUSTMENTS (SPECIFY)					
46	OTHER ADJUSTMENTS (SPECIFY)					
47	OTHER ADJUSTMENTS (SPECIFY)					
48	OTHER ADJUSTMENTS (SPECIFY)					
49	OTHER ADJUSTMENTS (SPECIFY)					
50	TOTAL (SUM OF LINES 1 THRU 49)		381,180			

<sup>(1)</sup> Description - all chapter references in this columnpertain to CMS Pub. 15-I.
(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN LIEU OF FORM CMS-2552-96(09/2000) STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

,	NGAN12A	ITIONS OR THE CLAIMING OF H	OME OFFICE COSIS.	AMOUNT OF		NET*	WKSHT A-7
				AMOUNT OF		ADJUST-	COL. REF.
	INE NO.	COOM CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	NACTIVITY.	MENTS	COL. REF.
ъ.	INE NO.	COST CENTER	EXPENSE ITEMS	COST	AMOUNT	MENTS 6	
1		Z DUADNA OV	3 DRUG SUPPLIES CONTRACTED P.S. SJRMC	106 504	106 504	6	
1 2	6	PHARMACI	DRUG SUPPLIES	1 455 710	196, 594	462.062	
3	6	ADMINISTRATIVE & GENERAL	CONTRACTED P.S. SJRMC	1,455,718	993,655	462,063	
	6	ADMINISTRATIVE & GENERAL	COPY SHOP FORMS SJRMC	19, 701	19,701		
4	6	ADMINISTRATIVE & GENERAL	INSURANCE EXPENSE	4,952	7,875	-2,923	12
4.0	L 6	ADMINISTRATIVE & GENERAL	CONTRACTED P.S. CREDENTIA	25,562	25,562		
4.0	2 5	EMPLOYEE BENEFITS	PENSION/401K EMPL MATCH	218, 794	133,373	85,421	
4.0	3 5	EMPLOYEE BENEFITS	RETIRE HEALTH	2,608	-26,974	29,582	
4.0	5 5	EMPLOYEE BENEFITS	FRINGE EXPENSE	5,808	10,337	-4,529	
4.0	5 5	EMPLOYEE BENEFITS	WORKMAN'S COMP	3,991	22,149	-18,158	
	7 50	PHYSICAL THERAPY	CONTRACTED P.S.	303,921	303,921		
4.0	3 52	SPEECH PATHOLOGY	CONTRACTED P.S.	116,160	116,160		
	51	OCCUPATIONAL THERAPY	CONTRACTED P.S.	82,517	82,517		
	50	PHYSICAL THERAPY	CONTRACTED P.S.	1,123	1,123		
	L 50	PHYSICAL THERAPY	CONTRACTED P.S.	540	540		
4.1	2 49	RESPIRATORY THERAPY	CONTRACTED P.S.	504,816	504,816		
4.1	3 53	ELECTROCARDIOLOGY	CONTRACTED P.S.	5,269	5,269		
4.1	53	ELECTROCARDIOLOGY	CONTRACTED P.S.	204	204		
4.1	5 53	ELECTROCARDIOLOGY	CONTRACTED P.S.	5,269	5,269		
4.1	5 41	RADIOLOGY-DIAGNOSTIC	CONTRACTED P.S.	1,564	1,564		
4.1	7 41	RADIOLOGY-DIAGNOSTIC	CONTRACTED P.S.	3,124	3,124		
4.1	3 41	RADIOLOGY-DIAGNOSTIC	CONTRACTED P.S.	29,639	29,639		
4.1	41	RADIOLOGY-DIAGNOSTIC	CONTRACTED P.S.	48,772	48,772		
4.2	41	RADIOLOGY-DIAGNOSTIC	CONTRACTED P.S.	9,806	9,806		
4.2	41	RADIOLOGY-DIAGNOSTIC	CONTRACTED P.S.	14,356	14,356		
4.2	2 41	RADIOLOGY-DIAGNOSTIC	CONTRACTED P.S.	72,953	72,953		
4.2	3 41	RADIOLOGY-DIAGNOSTIC	CONTRACTED P.S.	1,108	1,108		
4.2	42	RADIOLOGY-THERAPEUTIC	CONTRACTED P.S.	45,923	45, 923		
4.2	5 57	RENAL DIALYSIS	CONTRACTED P.S.	366,221	366,221		
	5 37	OPERATING ROOM	CONTRACTED P.S.	294,760	294,760		
4.2	7 37	OPERATING ROOM	CONTRACTED P.S.	38,837	38,837		
4.2	3 37	OPERATING ROOM	CONTRACTED P.S.	6.991	6.991		
	37	OPERATING ROOM	CONTRACTED P S	20.095	20.095		
	25	ADULTS & PEDIATRICS	CONTRACTED P.S.	16.582	16.582		
4.3	6	ADMINISTRATIVE & GENERAL	CONTRACTED P S - SOUTH B	326, 400	326,400		
4.3	2 6	ADMINISTRATIVE & GENERAL	POSTAGE	963	963		
4.3	3 3	NEW CAP REL COSTS-BLDG &	LEASE OF SPACE	462.135	462.135		10
4.3	1 4	NEW CAP REL COSTS-MURIE E	DRUG SUPPLIES CONTRACTED P.S. SJRMC COPY SHOP FORMS SJRMC INSURANCE EXPENSE CONTRACTED P.S. CREDENTIA PENSION/401K EMPL MATCH RETIRE HEALTH FRINGE EXPENSE WORKMAN'S COMP CONTRACTED P.S. CONT	27,216	27, 216		10
4.3		MEDICAL SUPPLIES CHARGED	MEDICAL SUPPLIES	17.853	17.853		
4.3		TAINIDY & ITNEN CEDUTCE	T ATINDDY	27 763	27 763		
	7 11	DIEMYDA TINEN SEKAICE	DIEMYDA	112 742	112 742		
4.3		VINTALCADVALIAE & CEMEDAL	MOLIND CADE	114,743 Q 120	114,743 Q 120		
5	, 0	MOMATC	HOURD CARE	4 067 401	4 416 025	551,456	
J		TOTMTO		4,70/,401	4,410,023	231,436	

\* THE AMOUNTS ON LINES 1-4 AND SUBSCRIPTS AS APPROPRIATE ARE TRANSFERRED IN DETAIL TO WORKSHEET A, COLUMN 6, LINES AS APPROPRIATE. POSITIVE AMOUNTS INCREASE COST AND NEGATIVE AMOUNTS DECREASE COST. FOR RELATED ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THIS INFORMATION IS USED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

	SYMBOL	NAME	PERCENTAGE	RELATED	ORGANIZATION(S) AND/OR HO	ME OFFICE
	(1)		OF	NAME	PERCENTAGE OF	TYPE OF
			OWNERSHIP		OWNERSHIP	BUSINESS
	1	2	3	4	5	6
1	G	SJRMC, INC.	0.00		0.00	PARENT GROUP
2	G	SJRMC, SOUTH BEND	0.00		0.00	HOSPITAL
3	G	SJRMC, MISHAWAKA	0.00		0.00	HOSPITAL
4	G	TRINITY HEALTH	0.00		0.00	PARENT GROUP
5			0.00		0.00	

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERELATIONSHIP TO RELATED ORGANIZATIONS:
  - A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.

  - CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS A FINANCIAL INTEREST IN RELATED ORGANIZATION.
  - INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
  - DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF
  - SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
    G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY.

SISTER ORGANIZATION

HEALTH FINANCIAL SYSTEMS	MCRS/PC-WIN	FOR OUR LADY OF PEACE	HOSPITAL, INC.	IN LIEU OF FORM	CMS-2552-96(9/1997)
			I PROVIDER NO:	I PERIOD:	I PREPARED 11/17/2008
COST ALLOCATION ST	ATISTICS		I 15-2018	I FROM 7/ 1/2007	I NOT A CMS WORKSHEET

I 15-2018 I FROM 7/ 1/2007 I
I I TO 6/30/2008 I

LINE		STATISTICS	CODE	STATIST	CICS DESCRIPTION		
	GENERAL SERVICE COST						
1	OLD CAP REL COSTS-BLDG & FIXT	3		SQUARE	FOOTAGE	ENTE	RED
2	OLD CAP REL COSTS-MVBLE EQUIP	3		SQUARE	FOOTAGE	ENTE	RED
3	NEW CAP REL COSTS-BLDG & FIXT	3		SQUARE	FOOTAGE	ENTE	RED
4	NEW CAP REL COSTS-MVBLE EQUIP	3		SQUARE	FOOTAGE	ENTE	RED
5	EMPLOYEE BENEFITS	#		ACCUM.	COST	NOT	ENTERED
6	ADMINISTRATIVE & GENERAL	#		ACCUM.	COST	NOT	ENTERED
9	LAUNDRY & LINEN SERVICE	#		ACCUM.	COST	NOT	ENTERED
11	DIETARY	#		ACCUM.	COST	NOT	ENTERED
14	NURSING ADMINISTRATION	#		ACCUM.	COST	NOT	ENTERED
16	PHARMACY	#		ACCUM.	COST	NOT	ENTERED
17	MEDICAL RECORDS & LIBRARY	#		ACCUM.	COST	NOT	ENTERED

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN LIEU OF FORM CMS-2552-96 (9/1997)

I PROVIDER NO: I PERIOD: I PREPARED 11/17/2008

COST ALLOCATION - GENERAL SERVICE COSTS I 15-2018 I TO 6/30/2008 I PART I

	COST CENTER	NET EXPENSES FOR COST	OLD CAP REL OSTS-BLDG &	C OLD CAP REL C OSTS-MVBLE E	NEW CAP REL C NEW OSTS-BLDG & OST	V CAP REL C	SUBTOTAL	EMPLOYEE BENE FITS
	DESCRIPTION	ALLOCATION		•	•		4	-
	GENERAL SERVICE COST CNTR	0	1	2	3	4	4a.00	5
001	OLD CAP REL COSTS-BLDG &							
001	OLD CAP REL COSTS-BLDG & OLD CAP REL COSTS-MVBLE E							
002	NEW CAP REL COSTS-MVBLE E	464,271			464,271			
003	NEW CAP REL COSTS-BLDG &	193,559			404,271	193,559		
005	EMPLOYEE BENEFITS	996,815				193,339	996,815	996,815
006	ADMINISTRATIVE & GENERAL	2,180,673			464,271	193,559	2,838,503	
009	LAUNDRY & LINEN SERVICE	87,759			404,271	193,339	87.759	,
011	DIETARY	103,055					103,055	
014	NURSING ADMINISTRATION	127,825					127,825	
014	PHARMACY	267,336					267,336	
017	MEDICAL RECORDS & LIBRARY	. ,					46,650	
	INPAT ROUTINE SRVC CNTRS	,					,	,
025	ADULTS & PEDIATRICS	2,543,405					2,543,405	263,601
035	NURSING FACILITY							
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	357,978					357,978	
041	RADIOLOGY-DIAGNOSTIC	321,688					321,688	
042	RADIOLOGY-THERAPEUTIC	45,923					45,923	
044	LABORATORY	241,197					241,197	
046	WHOLE BLOOD & PACKED RED	32,343					32,343	3,352
048	INTRAVENOUS THERAPY							
049	RESPIRATORY THERAPY	504,816					504,816	
050	PHYSICAL THERAPY	305,583					305,583	
051	OCCUPATIONAL THERAPY	82,517					82,517	,
052	SPEECH PATHOLOGY	116,160					116,160	
053	ELECTROCARDIOLOGY	10,742					10,742	
055	MEDICAL SUPPLIES CHARGED	319,854					319,854	
056	DRUGS CHARGED TO PATIENTS						898,429	
057	RENAL DIALYSIS OUTPAT SERVICE COST CNTRS	366,221					366,221	37,956
061	EMERGENCY							
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS NONREIMBURS COST CENTERS	10,614,799			464,271	193,559	10,614,799	996,815
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	10,614,799			464,271	193,559	10,614,799	996,815
2552-96	v1701.100							

	COST CENTER DESCRIPTION	SUBTOTAL	ADMINISTRATIV E & GENERAL	SUBTOTAL	LAUNDRY & LIN EN SERVICE	SUBTOTAL	DIETARY	SUBTOTAL
		5a.00	6	8a.00	9	10a.00	11	13a.00
	GENERAL SERVICE COST CNTR							
001	OLD CAP REL COSTS-BLDG &							
002	OLD CAP REL COSTS-MVBLE E							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL	3,132,685	3,132,685					
009	LAUNDRY & LINEN SERVICE	96,854	40,552	137,406	137,406			
011	DIETARY	113,736	47,620	161,356	2,116	163,472	163,472	
014	NURSING ADMINISTRATION	141,073	59,066	200,139	2,625	202,764	3,171	205,935
016	PHARMACY	295,043	123,532	418,575	5,490	424,065	6,633	430,698
017	MEDICAL RECORDS & LIBRARY INPAT ROUTINE SRVC CNTRS	51,485	21,556	73,041	958	73,999	1,157	75,156
025	ADULTS & PEDIATRICS	2,807,006	1,175,263	3,982,269	52,222	4,034,491	63,107	4,097,598
035	NURSING FACILITY ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	395,079	165,416	560,495	7,351	567,846	8,882	576,728
041	RADIOLOGY-DIAGNOSTIC	355,028	148,647	503,675	6,606	510,281	7,981	518,262
042	RADIOLOGY-THERAPEUTIC	50,683	21,220	71,903	943	72,846	1,139	73,985
044	LABORATORY	266,195	111,453	377,648	4,953	382,601	5,984	388,585
046	WHOLE BLOOD & PACKED RED	35,695	14,945	50,640	664	51,304	802	52,106
048	INTRAVENOUS THERAPY							
049	RESPIRATORY THERAPY	557,136	233,267	790,403	10,366	800,769	12,525	813,294
050	PHYSICAL THERAPY	337,254	141,205	478,459	6,275	484,734	7,582	492,316
051	OCCUPATIONAL THERAPY	91,069	38,130	129,199	1,694	130,893	2,047	132,940
052	SPEECH PATHOLOGY	128,199	53,676	181,875	2,385	184,260	2,882	187,142
053	ELECTROCARDIOLOGY	11,855	4,964	16,819	221	17,040	267	17,307
055	MEDICAL SUPPLIES CHARGED	353,004	147,799	500,803	6,568	507,371	7,936	515,307
056	DRUGS CHARGED TO PATIENTS	991,543	415,149	1,406,692	18,449	1,425,141	22,291	1,447,432
057	RENAL DIALYSIS OUTPAT SERVICE COST CNTRS	404,177	169,225	573,402	7,520	580,922	9,086	590,008
061	EMERGENCY SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	10,614,799	3,132,685	10,614,799	137,406	10,614,799	163,472	10,614,799
	NONREIMBURS COST CENTERS							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER	10 614 -00	2 120 625	10 (14	107 405	10 614 -00	160 450	10 614 700
103 2552-96	TOTAL v1701.100	10,614,799	3,132,685	10,614,799	137,406	10,614,799	163,472	10,614,799

	COST CENTER DESCRIPTION	NURSING ADMIN ISTRATION	SUBTOTAL	PHARMACY	SUBTOTAL	MEDICAL RECOR DS & LIBRARY	SUBTOTAL	I&R COST POST STEP- DOWN ADJ
		14	15a.00	16	16a.00	17	25	26
	GENERAL SERVICE COST CNTR							
001	OLD CAP REL COSTS-BLDG &							
002	OLD CAP REL COSTS-MVBLE E							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL							
009	LAUNDRY & LINEN SERVICE							
011	DIETARY							
014	NURSING ADMINISTRATION	205,935						
016	PHARMACY	8,521	439,219	439,219				
017	MEDICAL RECORDS & LIBRARY INPAT ROUTINE SRVC CNTRS	1,487	76,643	3,308	79,951	79,951		
025	ADULTS & PEDIATRICS	81,068	4,178,666	180,366	4,359,032	33,083	4,392,115	
035	NURSING FACILITY	,		,		•		
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	11,411	588,139	25,386	613,525	4,656	618,181	
041	RADIOLOGY-DIAGNOSTIC	10,254	528,516	22,813	551,329	4,184	555,513	
042	RADIOLOGY-THERAPEUTIC	1,464	75,449		78,706		79,303	
044	LABORATORY	7,688	396,273		413,378		416,515	
046	WHOLE BLOOD & PACKED RED	1,031	53,137		55,431		55,852	
048	INTRAVENOUS THERAPY	,	•	,	•		·	
049	RESPIRATORY THERAPY	16,091	829,385	35,800	865,185	6,566	871,751	
050	PHYSICAL THERAPY	9,740	502,056	21,671	523,727	3,975	527,702	
051	OCCUPATIONAL THERAPY	2,630	135,570	5,852	141,422	1,073	142,495	
052	SPEECH PATHOLOGY	3,703	190,845		199,083		200,594	
053	ELECTROCARDIOLOGY	342	17,649		18,411		18,551	
055	MEDICAL SUPPLIES CHARGED	10,195	525,502		548,185		552,345	
056	DRUGS CHARGED TO PATIENTS	28,637	1,476,069	63,713	1,539,782	11,685	1,551,467	
057	RENAL DIALYSIS	11,673	601,681	25,971	627,652	4,763	632,415	
	OUTPAT SERVICE COST CNTRS			-,-	, , , , , , , , , , , , , , , , , , , ,	,	, ,	
061	EMERGENCY							
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	205,935	10,614,799	439,219	10,614,799	79,951	10,614,799	
	NONREIMBURS COST CENTERS	,		,				
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	205,935	10,614,799	439,219	10,614,799	79,951	10,614,799	

TOTAL

		IOIME
	COST CENTER	
	DESCRIPTION	
		27
	GENERAL SERVICE COST CNTR	
001	OLD CAP REL COSTS-BLDG &	

001	OLD CAP REL COSTS-BLDG &
002	OLD CAP REL COSTS-MVBLE E
003	NEW CAP REL COSTS-BLDG &
004	NEW CAP REL COSTS-MVBLE E
005	EMPLOYEE BENEFITS
006	ADMINISTRATIVE & GENERAL
009	LAUNDRY & LINEN SERVICE
011	DIETARY
014	NURSING ADMINISTRATION
016	PHARMACY
017	MEDICAL DECORDS & LIDDARY

016	PHARMACY
017	MEDICAL RECORDS & LIBRARY

	INPAT ROUTINE SRVC CNTRS	
025	ADULTS & PEDIATRICS	4,392,115
035	NURSING FACILITY	
	ANCILLARY SRVC COST CNTRS	
037	OPERATING ROOM	618,181
041	RADIOLOGY-DIAGNOSTIC	555,513
042	RADIOLOGY-THERAPEUTIC	79,303
044	LABORATORY	416,515
046	WHOLE BLOOD & PACKED RED	55,852
048	INTRAVENOUS THERAPY	
049	RESPIRATORY THERAPY	871,751
050	PHYSICAL THERAPY	527,702

040	MHODE BLOOD & FACKED KED	33,632
048	INTRAVENOUS THERAPY	
049	RESPIRATORY THERAPY	871,751
050	PHYSICAL THERAPY	527,702
051	OCCUPATIONAL THERAPY	142,495
052	SPEECH PATHOLOGY	200,594
053	ELECTROCARDIOLOGY	18,551
055	MEDICAL SUPPLIES CHARGED	552,345
056	DRUGS CHARGED TO PATIENTS	1,551,467
057	RENAL DIALYSIS	632,415
	OURDAM CERTIFICE COCH CAMBO	

061	OUTPAT SERVICE COST CNTRS EMERGENCY	
	SPEC PURPOSE COST CENTERS	
095	SUBTOTALS	10,614,799
	WANTED THE COURT OF THE CO.	

NONREIMBURS COST CENTERS CROSS FOOT ADJUSTMENT NEGATIVE COST CENTER TOTAL 101 102 103

10,614,799

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN LIEU OF FORM CMS-2552-96 (9/1996)

I PROVIDER NO: I PERIOD: I PREPARED 11/17/2008

ALLOCATION OF NEW CAPITAL RELATED COSTS I 15-2018 I TO 6/30/2008 I PART III

		DIR ASSGNED				NEW CAP REL C		EMPLOYEE BENE
	COST CENTER	NEW CAPITAL	OSTS-BLDG &	OSTS-MVBLE E	OSTS-BLDG &	OSTS-MVBLE E	SUBTOTAL	FITS
	DESCRIPTION	REL COSTS						
		0	1	2	3	4	4a	5
	GENERAL SERVICE COST CNT							
001	OLD CAP REL COSTS-BLDG &							
002	OLD CAP REL COSTS-MVBLE							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE	E						
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL				464,271	193,559	657,830	
009	LAUNDRY & LINEN SERVICE							
011	DIETARY							
014	NURSING ADMINISTRATION							
016	PHARMACY							
017	MEDICAL RECORDS & LIBRAR							
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS							
035	NURSING FACILITY							
	ANCILLARY SRVC COST CNTR	.S						
037	OPERATING ROOM							
041	RADIOLOGY-DIAGNOSTIC							
042	RADIOLOGY-THERAPEUTIC							
044	LABORATORY							
046	WHOLE BLOOD & PACKED RED							
048	INTRAVENOUS THERAPY							
049	RESPIRATORY THERAPY							
050	PHYSICAL THERAPY							
051	OCCUPATIONAL THERAPY							
052	SPEECH PATHOLOGY							
053	ELECTROCARDIOLOGY							
055	MEDICAL SUPPLIES CHARGED							
056	DRUGS CHARGED TO PATIENT	S						
057	RENAL DIALYSIS							
	OUTPAT SERVICE COST CNTR	S						
061	EMERGENCY							
	SPEC PURPOSE COST CENTER	.S						
095	SUBTOTALS				464,271	193,559	657,830	
	NONREIMBURS COST CENTERS							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL				464,271	193,559	657,830	

	COST CENTER	E & GENERAL	LAUNDRY & LIN D EN SERVICE	IETAKY	NURSING ADMIN P	HARMACY	MEDICAL RECOR DS & LIBRARY	SUBTOTAL
	DESCRIPTION	6	9	11	14	16	17	25
	GENERAL SERVICE COST CNTF	-	9	11	14	10	17	25
001		•						
001	OLD CAP REL COSTS-BLDG & OLD CAP REL COSTS-MVBLE E							
002	NEW CAP REL COSTS-MVBLE E	•						
003	NEW CAP REL COSTS-BLDG &							
005	EMPLOYEE BENEFITS	•						
005	ADMINISTRATIVE & GENERAL	657,830						
009	LAUNDRY & LINEN SERVICE	8,515	8,515					
011	DIETARY	10,000	131	10,131				
011	NURSING ADMINISTRATION	12,403	163	10,131	12,762			
014	PHARMACY	25,940	340	411	528	27,219		
017	MEDICAL RECORDS & LIBRARY	,	59	72	92	27,219	4.955	
017	INPAT ROUTINE SRVC CNTRS	4,527	39	12	32	205	4,900	
025	ADULTS & PEDIATRICS	246,797	3,235	3,911	5,025	11,177	2,052	272,197
025	NURSING FACILITY	240,737	3,233	3,911	5,025	11,1//	2,032	212,191
055	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	34,735	456	550	707	1,573	288	38,309
041	RADIOLOGY-DIAGNOSTIC	31,214	409	494	635	1,414	259	34,425
041	RADIOLOGI-DIAGNOSIIC RADIOLOGY-THERAPEUTIC	4,456	58	71	91	202	37	4,915
044	LABORATORY	23,404	307	371	476	1,060	194	25,812
046	WHOLE BLOOD & PACKED RED	3,138	41	50	64	142	26	3,461
048	INTRAVENOUS THERAPY	3,130	72	50	04	142	20	3,401
049	RESPIRATORY THERAPY	48,983	643	776	997	2,219	407	54,025
050	PHYSICAL THERAPY	29,651	389	470	604	1,343	246	32,703
051	OCCUPATIONAL THERAPY	8,007	105	127	163	363	66	8,831
052	SPEECH PATHOLOGY	11,271	148	179	229	511	94	12,432
052	ELECTROCARDIOLOGY	1,042	14	17	21	47	9	1,150
055	MEDICAL SUPPLIES CHARGED	31,036	407	492	632	1,406	258	34,231
056	DRUGS CHARGED TO PATIENTS		1,144	1,381	1,775	3,948	724	96,148
057	RENAL DIALYSIS	35,535	466	563	723	1,609	295	39,191
037	OUTPAT SERVICE COST CNTRS		400	303	723	1,003	273	33,131
061	EMERGENCY							
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	657,830	8,515	10,131	12,762	27,219	4,955	657,830
333	NONREIMBURS COST CENTERS	057,050	0,313	10,131	12,,02	2,,219	4,755	037,030
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	657,830	8,515	10,131	12,762	27,219	4.955	657,830

		POST	TOTAL
	COST CENTER	STEPDOWN	
	DESCRIPTION	ADJUSTMENT	
	GDVDD11 GDD111GD GGGD GVD	26	27
	GENERAL SERVICE COST CNT	K	
001	OLD CAP REL COSTS-BLDG &	_	
002			
003			
004		E	
005			
006			
009			
011			
014			
016			
017			
	INPAT ROUTINE SRVC CNTRS		
025			272,197
035		~	
037	ANCILLARY SRVC COST CNTR. OPERATING ROOM	S	20 200
041			38,309 34,425
041			4,915
044			25,812
044			3,461
048			3,401
049			54,025
050			32,703
051			8,831
052			12,432
053			1,150
055			34,231
056			96,148
057			39,191
	OUTPAT SERVICE COST CNTR	S	,
061	EMERGENCY		
	SPEC PURPOSE COST CENTER	s	
095	SUBTOTALS		657,830
	NONREIMBURS COST CENTERS		
101	CROSS FOOT ADJUSTMENTS		
102	NEGATIVE COST CENTER		
103	TOTAL		657,830
0550	06 1701 100		

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN LIEU OF FORM CMS-2552-96 (9/1997)

I PROVIDER NO: I PERIOD: I PREPARED 11/17/2008

COST ALLOCATION - STATISTICAL BASIS I 15-2018 I TO 6/30/2008 I WORKSHEET B-1

	COST CENTER DESCRIPTION	OLD CAP REL OSTS-BLDG &		C NEW CAP REL E OSTS-BLDG &	C NEW CAP REL OSTS-MVBLE E		EMPLOYEE BENE FITS
		(SQUARE OOTAGE	F (SQUARE ) OOTAGE	F (SQUARE ) OOTAGE	F (SQUARE ) OOTAGE	F RECONCIL- ) IATION	( ACCUM. COST )
		1	2	3	4	5a.00	5
	GENERAL SERVICE COST						
001	OLD CAP REL COSTS-BLD	13,000					
002	OLD CAP REL COSTS-MVB		13,000				
003	NEW CAP REL COSTS-BLD			13,000			
004	NEW CAP REL COSTS-MVB				13,000		
005	EMPLOYEE BENEFITS					-996,815	9,617,984
006	ADMINISTRATIVE & GENE	13,000	13,000	13,000	13,000		2,838,503
009	LAUNDRY & LINEN SERVI						87,759
011	DIETARY						103,055
014	NURSING ADMINISTRATIO						127,825
016	PHARMACY						267,336
017	MEDICAL RECORDS & LIB INPAT ROUTINE SRVC CN						46,650
025	ADULTS & PEDIATRICS						2,543,405
035	NURSING FACILITY						
037	ANCILLARY SRVC COST C						257 272
037	OPERATING ROOM RADIOLOGY-DIAGNOSTIC						357,978 321,688
041	RADIOLOGY-THERAPEUTIC						45,923
044	LABORATORY						241,197
046	WHOLE BLOOD & PACKED						32,343
048	INTRAVENOUS THERAPY						32,343
049	RESPIRATORY THERAPY						504,816
050	PHYSICAL THERAPY						305,583
051	OCCUPATIONAL THERAPY						82,517
052	SPEECH PATHOLOGY						116,160
053	ELECTROCARDIOLOGY						10,742
055	MEDICAL SUPPLIES CHAR						319,854
056	DRUGS CHARGED TO PATI						898,429
057	RENAL DIALYSIS						366,221
	OUTPAT SERVICE COST C						
061	EMERGENCY						
	SPEC PURPOSE COST CEN						
095	SUBTOTALS	13,000	13,000	13,000	13,000	-996,815	9,617,984
	NONREIMBURS COST CENT						
101	CROSS FOOT ADJUSTMENT						
102	NEGATIVE COST CENTER						
103	COST TO BE ALLOCATED			464,271	193,559		996,815
104	(WRKSHT B, PART I)			25 51215			
104	UNIT COST MULTIPLIER			35.71315	14.88915		.103641
105	(WRKSHT B, PT I)				14.88913	04	.103641
105	COST TO BE ALLOCATED (WRKSHT B, PART II)						
106	UNIT COST MULTIPLIER						
100	(WRKSHT B, PT II)						
107	COST TO BE ALLOCATED						
10,	(WRKSHT B, PART III						
108	UNIT COST MULTIPLIER						
	(WRKSHT B, PT III)						
	, , , ,						

	COST CENTER DESCRIPTION		ADMINISTRATI E & GENERAL	v	LAUNDRY & LIN EN SERVICE	Ŋ	DIETARY	
		RECONCIL-	( ACCUM.	RECONCIL-	( ACCUM.	RECONCIL-	( ACCUM.	RECONCIL-
		IATION	COST	) IATION	COST	) IATION	COST	) IATION
		6a.00	6	9a.00	9	11a.00	11	14a.00
	GENERAL SERVICE COST							
001	OLD CAP REL COSTS-BLD							
002	OLD CAP REL COSTS-MVB							
003	NEW CAP REL COSTS-BLD							
004	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE	-3,132,685	7,482,114					
009	LAUNDRY & LINEN SERVI		96,854	-137,406	10,477,393			
011	DIETARY		113,736		161,356	-163,472	10,451,327	
014	NURSING ADMINISTRATIO		141,073		200,139		202,764	-205,935
016	PHARMACY		295,043		418,575		424,065	
017	MEDICAL RECORDS & LIB INPAT ROUTINE SRVC CN		51,485		73,041		73,999	
025	ADULTS & PEDIATRICS		2,807,006		3,982,269		4,034,491	
035	NURSING FACILITY ANCILLARY SRVC COST C							
037	OPERATING ROOM		395,079		560,495		567,846	
041	RADIOLOGY-DIAGNOSTIC		355,028		503,675		510,281	
042	RADIOLOGY-THERAPEUTIC		50,683		71,903		72,846	
044	LABORATORY		266,195		377,648		382,601	
046	WHOLE BLOOD & PACKED		35,695		50,640		51,304	
048	INTRAVENOUS THERAPY							
049	RESPIRATORY THERAPY		557,136		790,403		800,769	
050	PHYSICAL THERAPY		337,254		478,459		484,734	
051	OCCUPATIONAL THERAPY		91,069		129,199		130,893	
052	SPEECH PATHOLOGY		128,199		181,875		184,260	
053	ELECTROCARDIOLOGY		11,855		16,819		17,040	
055	MEDICAL SUPPLIES CHAR		353,004		500,803		507,371	
056	DRUGS CHARGED TO PATI		991,543		1,406,692		1,425,141	
057	RENAL DIALYSIS OUTPAT SERVICE COST C		404,177		573,402		580,922	
061	EMERGENCY							
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	-3,132,685	7,482,114	-137,406	10,477,393	-163,472	10,451,327	-205,935
	NONREIMBURS COST CENT							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER						4.60 4.00	
103	COST TO BE ALLOCATED		3,132,685		137,406		163,472	
104	(WRKSHT B, PART I)		41060		01011	-	01564	•
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)		.41869	10	.013115	•	.01564	L
105	COST TO BE ALLOCATED							
	(WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER							
	(WRKSHT B, PT II)							
107	COST TO BE ALLOCATED		657,830		8,515		10,131	
	(WRKSHT B, PART III		,		,		•	
108	UNIT COST MULTIPLIER		.08792	10	.000813	3	.00096	9
	(WRKSHT B, PT III)							

	COST CENTER DESCRIPTION	NURSING ADMIN		PHARMACY		MEDICAL RECOR DS & LIBRARY
		( ACCUM. COST )		( ACCUM. COST		
		14	16a.00	16	17a.00	17
001	GENERAL SERVICE COST					
001	OLD CAP REL COSTS-BLD					
002 003	OLD CAP REL COSTS-MVB NEW CAP REL COSTS-BLD					
003	NEW CAP REL COSTS-BLD NEW CAP REL COSTS-MVB					
005	EMPLOYEE BENEFITS					
005	ADMINISTRATIVE & GENE					
009	LAUNDRY & LINEN SERVI					
011	DIETARY					
014	NURSING ADMINISTRATIO	10.408.864				
016	PHARMACY		-439.219	10,175,580		
017	MEDICAL RECORDS & LIB INPAT ROUTINE SRVC CN	75,156	,		-79,951	10,534,848
025	ADULTS & PEDIATRICS	4,097,598		4,178,666		4,359,032
025	NURSING FACILITY	4,091,390		4,170,000		4,339,032
033	ANCILLARY SRVC COST C					
037	OPERATING ROOM	576,728		588,139		613,525
041	RADIOLOGY-DIAGNOSTIC	519 262				551,329
042	RADIOLOGY-THERAPEUTIC	73,985		75,449		78,706
044	LABORATORY	73,985 388,585		528,516 75,449 396,273		413,378
046	WHOLE BLOOD & PACKED	52,106		53,137		55,431
048	INTRAVENOUS THERAPY					
049	RESPIRATORY THERAPY	813,294		829,385 502,056 135,570 190,845 17,649 525,502		865,185
050	PHYSICAL THERAPY	492,316		502,056		523,727
051	OCCUPATIONAL THERAPY	132,940		135,570		141,422 199,083
052	SPEECH PATHOLOGY	132,940 187,142 17,307 515,307		190,845		199,083
053	ELECTROCARDIOLOGY	17,307		17,649		18,411
055	MEDICAL SUPPLIES CHAR	515,307		525,502		548,185
056	DRUGS CHARGED TO PATI	1,447,432 590,008		525,502 1,476,069		1,539,782
057	RENAL DIALYSIS	590,008		601,681		627,652
	OUTPAT SERVICE COST C					
061	EMERGENCY					
	SPEC PURPOSE COST CEN					
095	SUBTOTALS	10,408,864	-439,219	10,175,580	-79,951	10,534,848
	NONREIMBURS COST CENT					
101	CROSS FOOT ADJUSTMENT					
102	NEGATIVE COST CENTER			400 04-		
103	COST TO BE ALLOCATED	205,935		439,219		79,951
104	(PER WRKSHT B, PART					
104	UNIT COST MULTIPLIER	010705		04316	4	007599
105	(WRKSHT B, PT I) COST TO BE ALLOCATED	.019785		.04316	4	.007589
106	(PER WRKSHT B, PART UNIT COST MULTIPLIER					
100						
107	(WRKSHT B, PT II) COST TO BE ALLOCATED	12,762		27,219		4,955
107	(PER WRKSHT B, PART	12,702		21,213		4, 555
108	UNIT COST MULTIPLIER					
108	(WRKSHT B, PT III)	.001226		.00267	5	.000470

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN LIEU OF FORM CMS-2552-96 (05/1999)

I PROVIDER NO: I PERIOD: I PREPARED 11/17/2008

COMPUTATION OF RATIO OF RATIO OF RATIO OF CONTROL OF CONTRO

WKST A LINE NO	COST CENTER DESCRIPTION .	WKST B, PT I COL. 27	ADJUSTMENT	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS
		1	2	3	4	5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	4,392,115		4,392,115		4,392,115
35	NURSING FACILITY					
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	618,181		618,181		618,181
41	RADIOLOGY-DIAGNOSTIC	555,513		555,513		555,513
42	RADIOLOGY-THERAPEUTIC	79,303		79,303		79,303
44	LABORATORY	416,515		416,515		416,515
46	WHOLE BLOOD & PACKED RED	55,852		55,852		55,852
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	871,751		871,751		871,751
50	PHYSICAL THERAPY	527,702		527,702		527,702
51	OCCUPATIONAL THERAPY	142,495		142,495		142,495
52	SPEECH PATHOLOGY	200,594		200,594		200,594
53	ELECTROCARDIOLOGY	18,551		18,551		18,551
55	MEDICAL SUPPLIES CHARGED	552,345		552,345		552,345
56	DRUGS CHARGED TO PATIENTS	1,551,467		1,551,467		1,551,467
57	RENAL DIALYSIS	632,415		632,415		632,415
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY					
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	10,614,799		10,614,799		10,614,799
102	LESS OBSERVATION BEDS	10,011,133		,,		,,
103	TOTAL	10,614,799		10,614,799		10,614,799

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN LIEU OF FORM CMS-2552-96 (05/1999)

I PROVIDER NO: I PERIOD: I PREPARED 11/17/2008

COMPUTATION OF RATIO OF RATIO OF RATIO OF CONTROL OF CONTRO

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS	ь	,	•	9	10	11
25	ADULTS & PEDIATRICS	11,924,160		11,924,160			
25 35		11,924,160		11,924,160			
35	NURSING FACILITY						
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,041,082		1,041,082			
41	RADIOLOGY-DIAGNOSTIC	1,189,489		1,189,489			
42	RADIOLOGY-THERAPEUTIC	127,764		127,764			
44	LABORATORY	2,357,657		2,357,657	.176665	.176665	.176665
46	WHOLE BLOOD & PACKED RED	350,901		350,901	.159167	.159167	.159167
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	2,167,766		2,167,766	.402143	.402143	.402143
50	PHYSICAL THERAPY	503,274		503,274	1.048538	1.048538	1.048538
51	OCCUPATIONAL THERAPY	217,811		217,811	. 654214	. 654214	.654214
52	SPEECH PATHOLOGY	179,565		179,565	1.117111	1.117111	1.117111
53	ELECTROCARDIOLOGY	69,421		69,421	.267225	.267225	.267225
55	MEDICAL SUPPLIES CHARGED	706,345		706,345		.781976	.781976
56	DRUGS CHARGED TO PATIENTS	7,277,009		7,277,009			
57	RENAL DIALYSIS	238,835		238,835			
0,	OUTPAT SERVICE COST CNTRS	200,000		250,050	2.01/320	2.01/520	2.01/320
61	EMERGENCY						
91	OTHER REIMBURS COST CNTRS						
101		00 051 050		00 051 050			
101	SUBTOTAL	28,351,079		28,351,079			
102	LESS OBSERVATION BEDS						
103	TOTAL	28,351,079		28,351,079			

HEALTH FINANCIAL SYSTEMS	MCRS/PC-WIN	FOR C	OUR LADY	OF PE	EACE HOSPIT	AL,	INC.	IN	LIEU	OF	FORM	CMS-25	52-9	6(09/1997)
					I	1	PROVIDER	NO:	I	PERI	OD:		I	PREPARED 11/17/2008
APPORTIONMENT OF INPATIE	NT ROUTINE SERV	ICE.	CAPITAL	COSTS	s I	:	15-2018		I	FROM	1 7/	1/2007	I	WORKSHEET D
					I				I	TO	6/3	30/2008	I	PART I
TITLE XVIII, PART A								PPS	3					

			OLD CAPITAL			NEW CAPITAL	
WKST A	COST CENTER DESCRIPTION	CAPITAL REL	SWING BED	REDUCED CAP	CAPITAL REL	SWING BED	REDUCED CAP
LINE NO.		COST (B, II)	ADJUSTMENT	RELATED COST	COST (B, III)	ADJUSTMENT	RELATED COST
		1	2	3	4	5	6
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS				272,197		272,197
101	TOTAL				272,197		272,197

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN LIEU OF FORM CMS-2552-96 (09/1997)

I PROVIDER NO: I PERIOD: I PREPARED 11/17/2008

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS I 15-2018 I FROM 7/ 1/2007 I WORKSHEET D

I TO 6/30/2008 I PART I

TITLE XVIII, PART A PPS

OLD CAPITAL INPAT PROGRAM NEW CAPITAL INPAT PROGRAM PER DIEM OLD CAP CST PER DIEM NEW CAP CST 12 TOTAL INPATIENT
PATIENT DAYS PROGRAM DAYS
7 8 WKST A COST CENTER DESCRIPTION LINE NO. INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS 5,889 5,889 186,446 186,446 25 8,597 31.66 101 8,597

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN LIEU OF FORM CMS-2552-96 (09/1996)

I PROVIDER NO: I PERIOD: I PREPARED 11/17/2008

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS I 15-2018 I FROM 7/ 1/2007 I WORKSHEET D

COMPONENT NO: I TO 6/30/2008 I PART II

TITLE XVIII, PART A HOSPITAL FOR SHOPHALL FOR SHOPHALL

WKST A	COST CENTER DESCRIPTION	OLD CAPITAL	NEW CAPITAL	TOTAL	INPAT PROGRA		TAL
LINE NO.		RELATED COST	RELATED COST	CHARGES	CHARGES	CST/CHRG RATIO	COSTS
		1	2	3	4	5	6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM		38,309	1,041,082	559,46	1	
41	RADIOLOGY-DIAGNOSTIC		34,425	1,189,489	608,34	5	
42	RADIOLOGY-THERAPEUTIC		4,915	127,764	123,86	4	
44	LABORATORY		25,812	2,357,657	1,484,76	1	
46	WHOLE BLOOD & PACKED RED		3,461	350,901	285,26	4	
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY		54,025	2,167,766	1,260,73	1	
50	PHYSICAL THERAPY		32,703	503,274	331,89	5	
51	OCCUPATIONAL THERAPY		8,831	217,811	145,14	8	
52	SPEECH PATHOLOGY		12,432	179,565	94,01	8	
53	ELECTROCARDIOLOGY		1,150	69,421	55,75	9	
55	MEDICAL SUPPLIES CHARGED		34,231	706,345	693,76	3	
56	DRUGS CHARGED TO PATIENTS		96,148	7,277,009	4,797,60	6	
57	RENAL DIALYSIS		39,191	238,835	158,74	3	
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
	OTHER REIMBURS COST CNTRS						
101	TOTAL		385,633	16,426,919	10,599,35	8	

HEALTH FINANCIAL SYSTEMS	MCRS/PC-WIN	FOR OU	JR LADY	OF PEACE	HOSPITAL	, INC.	IN	LIEU OF F	ORM CMS-255	2-9	6(09/1996) CONTD
					I	PROVIDER	NO:	I PERIO	D:	I	PREPARED 11/17/2008
APPORTIONMENT OF INPATIEN	ANCILLARY	SERVICE	CAPITAL	COSTS	I	15-2018		I FROM	7/ 1/2007	I	WORKSHEET D
					I	COMPONENT	r no:	I TO	6/30/2008	I	PART II
					I	15-2018		I		I	
TITLE XVIII, PART A		HOSPI	ITAL				PPS	5			

WKST A	COST CENTER DESCRIPTION	NEW CAPITA	ıL
LINE NO.		CST/CHRG RATIO	COSTS
		7	8
	ANCILLARY SRVC COST CNTR	s	
37	OPERATING ROOM	.036797	20,586
41	RADIOLOGY-DIAGNOSTIC	.028941	17,606
42	RADIOLOGY-THERAPEUTIC	.038469	4,765
44	LABORATORY	.010948	16,255
46	WHOLE BLOOD & PACKED RED	.009863	2,814
48	INTRAVENOUS THERAPY		
49	RESPIRATORY THERAPY	.024922	31,420
50	PHYSICAL THERAPY	.064981	21,567
51	OCCUPATIONAL THERAPY	.040544	5,885
52	SPEECH PATHOLOGY	.069234	6,509
53	ELECTROCARDIOLOGY	.016566	924
55	MEDICAL SUPPLIES CHARGED	.048462	33,621
56	DRUGS CHARGED TO PATIENTS	s .013213	63,391
57	RENAL DIALYSIS	.164092	26,048
	OUTPAT SERVICE COST CNTR	S	
61	EMERGENCY		
	OTHER REIMBURS COST CNTR	S	
101	TOTAL		251,391

HEALTH FINANCIAL SYSTEMS

IN LIEU OF FORM CMS-2552-96(11/1998)
NO: I PERIOD: I PREPARED 11/17/2008
I FROM 7/ 1/2007 I WORKSHEET D
I TO 6/30/2008 I PART III MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN I PROVIDER NO: ENT ROUTINE I 15-2018 APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS TITLE XVIII, PART A

PPS

TOTAL COSTS 4 TOTAL
PATIENT DAYS
5 WKST A COST CENTER DESCRIPTION LINE NO. NONPHYSICIAN MED EDUCATN ANESTHETIST COST PER DIEM SWING BED COST 2 ADJ AMOUNT
3 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS NURSING FACILITY TOTAL 25 8,597 35 101 8,597

HEALTH FINANCIAL SYSTEMS

MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN LIEU OF FORM CMS-2552-96(11/1998)

I PROVIDER NO: I PERIOD: I PREPARED 11/17/2008

LENT ROUTINE I 15-2018 I FROM 7/ 1/2007 I WORKSHEET D

UGH COSTS I I TO 6/30/2008 I PART III APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS TITLE XVIII, PART A

INPATIENT INPAT PROGRAM
PROG DAYS PASS THRU COST
7 8
5,889 WKST A COST CENTER DESCRIPTION LINE NO.

25 ADULTS & PEDIATRICS NURSING FACILITY 35 101 5,889

IN LIEU OF FORM CMS-2552-96(04/2005)

IO: I PERIOD: I PREPARED 11/17/2008

I FROM 7/ 1/2007 I WORKSHEET D

NO: I TO 6/30/2008 I PART IV

I I HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN APPORTIONMENT OF INPATIENT ANCILLARY SERVICE I PROVIDER NO: OTHER PASS THROUGH COSTS I 15-2018 COMPONENT NO: 15-2018 TITLE XVIII, PART A HOSPITAL PPS

WKST A	COST CENTER DESCRIPTION	NONPHYSICIAN		MED ED NRS	MED ED ALLIED	MED ED ALL	BLOOD CLOT FOR
LINE NO.		ANESTHETIST		SCHOOL COST	HEALTH COST	OTHER COSTS	HEMOPHILIACS
		1	1.01	2	2.01	2.02	2.03

ANCILLARY SRVC COST CNTRS OPERATING ROOM

OPERATING ROOM
RADIOLOGY-DIAGNOSTIC
RADIOLOGY-THERAPEUTIC
LABORATORY
WHOLE BLOOD & PACKED RED
INTRAVENOUS THERAPY
RESPIRATORY THERAPY
PHYSICAL THERAPY
OCCUMENTAL THERAPY

37 41 42 44 46 48 49 50 51 52 53 55 56 57 PHYSICAL THERAPY
OCCUPATIONAL THERAPY
SPEECH PATHOLOGY
ELECTROCARDIOLOGY
MEDICAL SUPPLIES CHARGED
DRUGS CHARGED TO PATIENTS
RENAL DIALYSIS
OUTPAT SERVICE COST CNTRS
EMPERGROCY

61 EMERGENCY

OTHER REIMBURS COST CNTRS

HEALTH FINANCIAL SYSTEMS MCRS/PC-WI	N FOR OUR LADY OF PE	EACE HOSPITAL, INC.	IN LIEU OF	FORM CMS-2552-	96(04/2005) CONTD
APPORTIONMENT OF INPATIENT ANCILLA	RY SERVICE	I PROVID	ER NO: I PERI	OD: I	PREPARED 11/17/2008
OTHER PASS THROUGH COSTS		I 15-201	8 I FROM	7/ 1/2007 I	WORKSHEET D
		I COMPON	ENT NO: I TO	6/30/2008 I	PART IV
		I 15-201	8 I	I	
TITLE XVIII, PART A	HOSPITAL		PPS		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST O/P RATIO OF TO CHARGES CST TO CHARGES 5 5.01	INPAT PROG INPAT PROG CHARGE PASS THRU COST 6 7
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM			1,041,082	!	559,461
41	RADIOLOGY-DIAGNOSTIC			1,189,489	,	608,345
42	RADIOLOGY-THERAPEUTIC			127,764	i	123,864
44	LABORATORY			2,357,657	l .	1,484,761
46	WHOLE BLOOD & PACKED RED			350,901		285,264
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY			2,167,766	វ	1,260,731
50	PHYSICAL THERAPY			503,274	i	331,895
51	OCCUPATIONAL THERAPY			217,811	•	145,148
52	SPEECH PATHOLOGY			179,565	j	94,018
53	ELECTROCARDIOLOGY			69,421	•	55,759
55	MEDICAL SUPPLIES CHARGED			706,345	j	693,763
56	DRUGS CHARGED TO PATIENTS			7,277,009	,	4,797,606
57	RENAL DIALYSIS			238,835	,	158,743
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY					
	OTHER REIMBURS COST CNTRS					
101	TOTAL			16,426,919	,	10,599,358

IN LIEU OF FORM CMS-2552-96(04/2005) CONTD
NO: I PERIOD: I PREPARED 11/17/2008
I FROM 7/ 1/2007 I WORKSHEET D
NO: I TO 6/30/2008 I PART IV
I I I TH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. APPORTIONMENT OF INPATIENT ANCILLARY SERVICE I PROVI HEALTH FINANCIAL SYSTEMS PROVIDER NO: 15-2018 OTHER PASS THROUGH COSTS COMPONENT NO: 15-2018 TITLE XVIII, PART A HOSPITAL PPS OUTPAT PROG OUTPAT PROG OUTPAT PROG OUTPAT PROG CHARGES D,V COL 5.03 D,V COL 5.04 PASS THRU COST 8 8.01 8.02 9 WKST A COST CENTER DESCRIPTION COL 8.01 COL 8.02 LINE NO. \* COL 5 9.01 \* COL 5 9.02 ANCILLARY SRVC COST CNTRS OPERATING ROOM 37 RADIOLOGY-DIAGNOSTIC RADIOLOGY-THERAPEUTIC 41 42 44 46 48 49 50 51 52 53 55 56 LABORATORY
WHOLE BLOOD & PACKED RED
INTRAVENOUS THERAPY RESPIRATORY THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED DRUGS CHARGED TO PATIENTS RENAL DIALYSIS
OUTPAT SERVICE COST CNTRS 57 61 EMERGENCY

2552-96 v1701.100

OTHER REIMBURS COST CNTRS

טפאוייט	FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE H	OCRITAL INC. IN	TIPH OF FORM CMC_2552_96 (05/2004)	
		I PROVIDER NO:	I PERIOD: I PREPARED 1	
COMPU	TATION OF INPATIENT OPERATING COST		I FROM 7/ 1/2007 I WORKSHEE I TO 6/30/2008 I PART I I I	
	TITLE XVIII PART A HOSPITAL	PPS		
PART I	- ALL PROVIDER COMPONENTS		1	
			1	
	INPATIENT DAYS			
1 2	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BE		8,597 8,597	
3 4	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS) SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM D	(244	8,597	
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE		8,337	
6	THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE	ROOM DAYS) AFTER		
7	DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, EN	TER 0 ON THIS LINE)		
	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD			
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, EN			
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE		5,889	
10	(EXCLUDING SWING-BED AND NEWBORN DAYS) SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVII	I ONLY (INCLUDING		
11	PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTI SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVII			
- 11	PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING			
12	YEAR, ENTER 0 ON THIS LINE) SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V &	XIX ONLY (INCLUDING		
	PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTI	NG PERIOD		
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & X PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING			
14	YEAR, ENTER 0 ON THIS LINE) MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PR	ОСРАМ		
	(EXCLUDING SWING-BED DAYS)	COTTAL		
15 16	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY) NURSERY DAYS (TITLE V OR XIX ONLY)			
	SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SER	VICES THROUGH		
18	DECEMBER 31 OF THE COST REPORTING PERIOD  MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SER	VICES AFTER		
19	DECEMBER 31 OF THE COST REPORTING PERIOD MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERV	TCES THROUGH		
	DECEMBER 31 OF THE COST REPORTING PERIOD			
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERV DECEMBER 31 OF THE COST REPORTING PERIOD	ICES AFTER		
21 22	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DEC	יבאסבס 31 אב ידעב כאפיד	4,392,115	
	REPORTING PERIOD			
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEM REPORTING PERIOD	BER 31 OF THE COST		
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECE REPORTING PERIOD	MBER 31 OF THE COST		
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMB	ER 31 OF THE COST		
26	REPORTING PERIOD TOTAL SWING-BED COST (SEE INSTRUCTIONS)			
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED CO PRIVATE ROOM DIFFERENTIAL ADJ		4,392,115	
28 29	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	-BED CHARGES)	11,817,318	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		11,817,318	
31 32	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO AVERAGE PRIVATE ROOM PER DIEM CHARGE		.371668	
33 34	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL		1,374.59	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL			
36 37	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED CO	ST AND PRIVATE ROOM	4,392,115	
	COST DIFFERENTIAL			

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HEALTH FINANCIAL SYSTEMS
                                MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC.
                                                                                              IN LIEU OF FORM CMS-2552-96(05/2004) CONTD
                                                                                                   I PERIOD: I PREPARED 11/17/2008
I FROM 7/ 1/2007 I WORKSHEET D-1
                                                                                  PROVIDER NO:
 COMPUTATION OF INPATIENT OPERATING COST
                                                                                  15-2018
                                                                                                    I TO
                                                                                  COMPONENT NO:
                                                                                                             6/30/2008 I
                                                                                                                                 PART TT
                                                                                  15-2018
             TITLE XVIII PART A
                                              HOSPITAL
                                                                                     PPS
PART II - HOSPITAL AND SUBPROVIDERS ONLY
                                                                                                                     1
                                         PROGRAM INPATIENT OPERATING COST BEFORE
                                              PASS THROUGH COST ADJUSTMENTS
  38
         ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM
                                                                                                                      510.89
  39
         PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST
                                                                                                                   3,008,631
        MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST
  40
                                                                                                                   3,008,631
  41
                                                  TOTAL
                                                                  TOTAL
                                                                                  AVERAGE
                                                                                                   PROGRAM
                                                                                                                    PROGRAM
                                                 I/P COST
                                                                 I/P DAYS
                                                                                  PER DIEM
                                                                                                    DAYS
                                                                                                                      COST
  42
        NURSERY (TITLE V & XIX ONLY)
INTENSIVE CARE TYPE INPATIENT
         HOSPITAL UNITS
         INTENSIVE CARE UNIT
  43
  44
         CORONARY CARE UNIT
  45
        BURN INTENSIVE CARE UNIT
         SURGICAL INTENSIVE CARE UNIT
  46
  47
        OTHER SPECIAL CARE
  48
        PROGRAM INPATIENT ANCILLARY SERVICE COST
                                                                                                                   4.056.485
        TOTAL PROGRAM INPATIENT COSTS
  49
                                                                                                                   7,065,116
                                                 PASS THROUGH COST ADJUSTMENTS
        PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
                                                                                                                     186,446
  51
        PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
                                                                                                                     251,391
         TOTAL PROGRAM EXCLUDABLE COST
                                                                                                                     437,837
        TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS
                                                                                                                   6,627,279
                                                 TARGET AMOUNT AND LIMIT COMPUTATION
        PROGRAM DISCHARGES
  55
        TARGET AMOUNT PER DISCHARGE
TARGET AMOUNT
  56
  57
         DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
  58
        BONUS PAYMENT
  58.01 LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED
        AND COMPOUNDED BY THE MARKET BASKET
  58.02 LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET
        BASKET
  58.03 IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE
        LESSER OF 50\% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 \times 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56)
         OTHERWISE ENTER ZERO.
  58 04 RELIEF PAYMENT
       ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
  59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
  59.02 PROGRAM DISCHARGES PRIOR TO JULY 1
  59.03 PROGRAM DISCHARGES AFTER JULY 1
  59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)
  59.05 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1
  (SEE INSTRUCTIONS) (LTCH ONLY)
59.06 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
  (SEE INSTRUCTIONS) (LTCH ONLY)
59.07 REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
  59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)
                                                PROGRAM INPATIENT ROUTINE SWING BED COST
  60
        MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST
        REPORTING PERIOD (SEE INSTRUCTIONS)
  61
         MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST
         REPORTING PERIOD (SEE INSTRUCTIONS)
        TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
        TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE
  63
        COST REPORTING PERIOD
  64
        TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE
        COST REPORTING PERIOD
```

TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

65

IN LIEU OF FORM CMS-2552-96(05/2004) CONTD
O: I PERIOD: I PREPARED 11/17/2008
I FROM 7/ 1/2007 I WORKSHEET D-1 HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. PROVIDER NO: COMPUTATION OF INPATIENT OPERATING COST 15-2018 COMPONENT NO: I TO PART III 6/30/2008 I 15-2018 TITLE XVIII PART A HOSPITAL PPS PART III - SKILLED NURSING FACILITY. NURSINGFACILITY & ICF/MR ONLY 1 SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM PROGRAM ROUTINE SERVICE COST
MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM 68 69 70 71 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS
CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS 72 73 74 75 76 PER DIEM CAPITAL-RELATED COSTS PROGRAM CAPITAL-RELATED COSTS INPATIENT ROUTINE SERVICE COST AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION 77 78 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION INPATIENT ROUTINE SERVICE COST LIMITATION 79 REASONABLE INPATIENT ROUTINE SERVICE COSTS PROGRAM INPATIENT ANCILLARY SERVICES
UTILIZATION REVIEW - PHYSICIAN COMPENSATION 80 82 TOTAL PROGRAM INPATIENT OPERATING COSTS PART IV - COMPUTATION OF OBSERVATION BED COST TOTAL OBSERVATION BED DAYS ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 510.89 84 OBSERVATION BED COST 85 COMPUTATION OF OBSERVATION BED PASS THROUGH COST OBSERVATION BED COLUMN 1 TOTAL ROUTINE DIVIDED BY OBSERVATION PASS THROUGH COST COST COLUMN 2 BED COST COST 1 2 4,392,115 3 5 OLD CAPITAL-RELATED COST 86 NEW CAPITAL-RELATED COST 272,197 4,392,115 .061974 NON PHYSICIAN ANESTHETIST 4.392.115 88

2552-96 v1701.100

89 MEDICAL EDUCATION 89.01 MEDICAL EDUCATION - ALLIED HEA 89.02 MEDICAL EDUCATION - ALL OTHER

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HEALTH FINANCIAL SYSTEMS
                                    MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC.
                                                                                                           IN LIEU OF FORM CMS-2552-96(05/2004)
                                                                                                                 I PERIOD: I PREPARED 11/17/2008
I FROM 7/ 1/2007 I WORKSHEET D-1
                                                                                              PROVIDER NO:
 COMPUTATION OF INPATIENT OPERATING COST
                                                                                              15-2018
                                                                                              COMPONENT NO:
                                                                                                                  I TO
                                                                                                                            6/30/2008 I
                                                                                                                                                   PART T
                                                                                              15-2018
               TITLE XIX - I/P
                                                     HOSPITAL
                                                                                                 OTHER
PART T - ALL PROVIDER COMPONENTS
                                                                                                                                      1
                                                       INPATIENT DAYS
          INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN) INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)
                                                                                                                                        8,597
                                                                                                                                        8,597
          PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)
SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)
                                                                                                                                        8,597
          TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS)
          THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
          TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER
          DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE) TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS)
          THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER
    8
          DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)
    9
          TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM
          (EXCLUDING SWING-BED AND NEWBORN DAYS)
          SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
  10
          SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR
  11
          YEAR, ENTER 0 ON THIS LINE)
SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING
  12
          PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
          SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR
  13
          YEAR, ENTER 0 ON THIS LINE)
MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM
  14
          CEXCLUDING SWING-BED DAYS)
TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)
NURSERY DAYS (TITLE V OR XIX ONLY)
  15
  16
                                                       SWING-BED ADJUSTMENT
  17
          MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH
          DECEMBER 31 OF THE COST REPORTING PERIOD
          MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER
  18
          DECEMBER 31 OF THE COST REPORTING PERIOD
          MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH
  19
          DECEMBER 31 OF THE COST REPORTING PERIOD MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER
  20
          DECEMBER 31 OF THE COST REPORTING PERIOD
          TOTAL GENERAL INPATIENT ROUTINE SERVICE COST
                                                                                                                                  4.392.115
  21
  22
          SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST
          REPORTING PERIOD
          SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST
          REPORTING PERIOD
          SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST
  24
          REPORTING PERIOD
  25
          SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST
          REPORTING PERIOD
          TOTAL SWING-BED COST (SEE INSTRUCTIONS)
GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST
  26
                                                                                                                                  4,392,115
                                              PRIVATE ROOM DIFFERENTIAL ADJUSTMENT
          GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)
PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)
                                                                                                                                 11,817,318
  29
          SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)
                                                                                                                                 11.817.318
  31
          GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO
                                                                                                                                      371668
  32
          AVERAGE PRIVATE ROOM PER DIEM CHARGE
          AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE
AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL
  33
                                                                                                                                    1,374.59
          AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL
  36
          PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT
          GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM
                                                                                                                                  4,392,115
```

COST DIFFERENTIAL

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HEALTH FINANCIAL SYSTEMS
                                MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC.
                                                                                               IN LIEU OF FORM CMS-2552-96(05/2004) CONTD
                                                                                                     I PERIOD: I PREPARED 11/17/2008
I FROM 7/ 1/2007 I WORKSHEET D-1
                                                                                   PROVIDER NO:
 COMPUTATION OF INPATIENT OPERATING COST
                                                                                   15-2018
                                                                                                     I TO
                                                                                   COMPONENT NO:
                                                                                                               6/30/2008 I
                                                                                                                                   PART TT
                                                                                   15-2018
             TITLE XIX - I/P
                                               HOSPITAL
                                                                                       OTHER
PART II - HOSPITAL AND SUBPROVIDERS ONLY
                                                                                                                        1
                                         PROGRAM INPATIENT OPERATING COST BEFORE
                                               PASS THROUGH COST ADJUSTMENTS
  38
         ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM
                                                                                                                        510.89
  39
         PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST
        MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST
  40
  41
                                                  TOTAL
                                                                   TOTAL
                                                                                   AVERAGE
                                                                                                    PROGRAM
                                                                                                                     PROGRAM
                                                 I/P COST
                                                                  I/P DAYS
                                                                                   PER DIEM
                                                                                                      DAYS
                                                                                                                        COST
  42
        NURSERY (TITLE V & XIX ONLY)
INTENSIVE CARE TYPE INPATIENT
         HOSPITAL UNITS
         INTENSIVE CARE UNIT
  43
  44
         CORONARY CARE UNIT
  45
        BURN INTENSIVE CARE UNIT
        SURGICAL INTENSIVE CARE UNIT
  46
  47
        OTHER SPECIAL CARE
  48
        PROGRAM INPATIENT ANCILLARY SERVICE COST
                                                                                                                         2,525
        TOTAL PROGRAM INPATIENT COSTS
  49
                                                                                                                         2,525
                                                 PASS THROUGH COST ADJUSTMENTS
        PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
  51
        PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
         TOTAL PROGRAM EXCLUDABLE COST
        TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS
                                                 TARGET AMOUNT AND LIMIT COMPUTATION
        PROGRAM DISCHARGES
  55
        TARGET AMOUNT PER DISCHARGE
TARGET AMOUNT
  56
  57
         DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
  58
        BONUS PAYMENT
  58.01 LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED
        AND COMPOUNDED BY THE MARKET BASKET
  58.02 LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET
        BASKET
  58.03 IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE
        LESSER OF 50\% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 \times 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56)
         OTHERWISE ENTER ZERO.
  58 04 RELIEF PAYMENT
        ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
  59.01 allowable inpatient cost per discharge (line 59 / line 54) (ltch only) 59.02 program discharges prior to July 1
  59.03 PROGRAM DISCHARGES AFTER JULY 1
  59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)
  59.05 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1
  (SEE INSTRUCTIONS) (LTCH ONLY)
59.06 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
  (SEE INSTRUCTIONS) (LTCH ONLY)
59.07 REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
  59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)
                                                PROGRAM INPATIENT ROUTINE SWING BED COST
  60
        MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST
        REPORTING PERIOD (SEE INSTRUCTIONS)
  61
         MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST
         REPORTING PERIOD (SEE INSTRUCTIONS)
         TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
        TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE
  63
         COST REPORTING PERIOD
  64
         TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE
        COST REPORTING PERIOD
```

TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

65

IN LIEU OF FORM CMS-2552-96(05/2004) CONTD
O: I PERIOD: I PREPARED 11/17/2008
I FROM 7/ 1/2007 I WORKSHEET D-1 MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. PROVIDER NO: COMPUTATION OF INPATIENT OPERATING COST 15-2018 COMPONENT NO: I TO 6/30/2008 I PART III 15-2018 TITLE XIX - I/P HOSPITAL OTHER PART III - SKILLED NURSING FACILITY. NURSINGFACILITY & ICF/MR ONLY 1 SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM PROGRAM ROUTINE SERVICE COST
MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM 68 69 70 71 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS
CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS 72 73 74 75 76 PER DIEM CAPITAL-RELATED COSTS PROGRAM CAPITAL-RELATED COSTS INPATIENT ROUTINE SERVICE COST AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION 77 78 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION INPATIENT ROUTINE SERVICE COST LIMITATION 79 REASONABLE INPATIENT ROUTINE SERVICE COSTS PROGRAM INPATIENT ANCILLARY SERVICES
UTILIZATION REVIEW - PHYSICIAN COMPENSATION 80 82 TOTAL PROGRAM INPATIENT OPERATING COSTS PART IV - COMPUTATION OF OBSERVATION BED COST TOTAL OBSERVATION BED DAYS ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 510.89 84 OBSERVATION BED COST 85 COMPUTATION OF OBSERVATION BED PASS THROUGH COST OBSERVATION BED COLUMN 1 TOTAL ROUTINE DIVIDED BY OBSERVATION PASS THROUGH COST COST COLUMN 2 BED COST COST 1 2 3 5 OLD CAPITAL-RELATED COST 86

2552-96 v1701.100

88

NEW CAPITAL-RELATED COST NON PHYSICIAN ANESTHETIST

MEDICAL EDUCATION 89.01 MEDICAL EDUCATION - ALLIED HEA 89.02 MEDICAL EDUCATION - ALL OTHER

HEALTH FINANCIAL SYSTEMS

WKST A	COST CENTER DESCRIPTION	RATIO COST	INPATIENT	INPATIENT
LINE NO.		TO CHARGES	CHARGES	COST
		1	2	3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		7,608,258	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.593787	559,461	332,201
41	RADIOLOGY-DIAGNOSTIC	.467018	608,345	284,108
42	RADIOLOGY-THERAPEUTIC	. 620699	123,864	76,882
44	LABORATORY	.176665	1,484,761	262,305
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	.159167	285,264	45,405
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	.402143	1,260,731	506,994
50	PHYSICAL THERAPY	1.048538	331,895	348,005
51	OCCUPATIONAL THERAPY	. 654214	145,148	94,958
52	SPEECH PATHOLOGY	1.117111	94,018	105,029
53	ELECTROCARDIOLOGY	. 267225	55,759	14,900
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.781976	693,763	542,506
56	DRUGS CHARGED TO PATIENTS	.213201	4,797,606	1,022,854
57	RENAL DIALYSIS	2.647916		420,338
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		10,599,358	4,056,485
102	LESS PBP CLINIC LABORATORY SERVICES -			
	PROGRAM ONLY CHARGES			
103	NET CHARGES		10,599,358	

WKST A LINE NO	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		4,800	
	ANCILLARY SRVC COST CNTRS		,	
37	OPERATING ROOM	.593787		
41	RADIOLOGY-DIAGNOSTIC	.467018	127	59
42	RADIOLOGY-THERAPEUTIC	. 620699		
44	LABORATORY	.176665	667	118
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	.159167		
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	.402143		
50	PHYSICAL THERAPY	1.048538	394	413
51	OCCUPATIONAL THERAPY	.654214	331	217
52	SPEECH PATHOLOGY	1.117111	675	754
53	ELECTROCARDIOLOGY	.267225		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.781976	909	711
56	DRUGS CHARGED TO PATIENTS	.213201	1,189	253
57	RENAL DIALYSIS	2.647916		
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		4,292	2,525
102	LESS PBP CLINIC LABORATORY SERVICES -			
	PROGRAM ONLY CHARGES			
103	NET CHARGES		4,292	

ANALYSIS OF PAYMENTS TO PROVIDE		PEACE	I	PROVIDE 15-2018	R NO:	PERION	D: 7/ 1/2007	I PREPARED 11/17/2008 I WORKSHEET E-1
					NT NO: 1		6/30/2008	I
TITLE XVIII	HOSPITAL							
DESC	CRIPTION				ART A	104/DF	PART	
			MM/DD/11	11	AMOUNT 2			AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID	TO PROVIDER		_		6,164,025		•	*
2 INTERIM PAYMENTS PAYABLE ON EITHER SUBMITTED OR TO BE SI INTERMEDIARY, FOR SERVICES I REPORTING PERIOD. IF NONE,	INDIVIDUAL BILLS, UBMITTED TO THE RENDERED IN THE COST				NONE			NONE
ENTER A ZERO.								
3 LIST SEPARATELY EACH RETROAG AMOUNT BASED ON SUBSEQUENT								
RATE FOR THE COST REPORTING OF EACH PAYMENT. IF NONE,	PERIOD. ALSO SHOW DATE							
ZERO. (1)								
	ADJUSTMENTS TO PROVIDER							
	ADJUSTMENTS TO PROVIDER							
	ADJUSTMENTS TO PROVIDER							
	ADJUSTMENTS TO PROVIDER							
	ADJUSTMENTS TO PROVIDER ADJUSTMENTS TO PROGRAM							
	ADJUSTMENTS TO PROGRAM							
	ADJUSTMENTS TO PROGRAM							
	ADJUSTMENTS TO PROGRAM							
	ADJUSTMENTS TO PROGRAM							
SUBTOTAL	120001121112 10 111001121	.99			NONE			NONE
4 TOTAL INTERIM PAYMENTS					6,164,025			
TO BE COMPLETED BY INTERM	EDIARY							
5 LIST SEPARATELY EACH TENTAT								
AFTER DESK REVIEW. ALSO SHO								
IF NONE, WRITE "NONE" OR EN								
	TENTATIVE TO PROVIDER							
		.02						
	TENTATIVE TO PROVIDER							
	TENTATIVE TO PROGRAM TENTATIVE TO PROGRAM							
		.51						
SUBTOTAL		. 52 . 99			NONE			NONE
6 DETERMINED NET SETTLEMENT	SETTLEMENT TO PROVIDER				NONE			NONE
AMOUNT (BALANCE DUE)								
BASED ON COST REPORT (1)	TT TMV							
7 TOTAL MEDICARE PROGRAM LIAB: NAME OF INTERMEDIARY: Palmo								
INTERMEDIARY NO: 00000	ECCO GBA - NH-100							
INIERMEDIAKI NO. 0000								
SIGNATURE OF AUTHORIZED PER	SOM:							

<sup>(1)</sup> ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

```
I PERIOD: I PREPARED 11/17/2008
I FROM 7/ 1/2007 I WORKSHEET E-3
                                                                                                    PROVIDER NO:
                  CALCULATION OF REIMBURSEMENT SETTLEMENT
                                                                                                    15-2018
                                                                                                                         I TO
                                                                                                    COMPONENT NO:
                                                                                                                                    6/30/2008 I
                                                                                                                                                              PART T
                                                                                                    15-2018
PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS AND LTCH PPS AND IPF PPS
                                                               HOSPITAL.
          INPATIENT HOSPITAL SERVICES (SEE INSTRUCTIONS)
   1.01 HOSPITAL SPECIFIC AMOUNT (SEE INSTRUCTIONS)
    1.02 ENTER FROM THE PS&R, THE IRF PPS PAYMENT
                                                                                                                   6,185,705
   1.03 MEDICAID SSI RATIO (IRF PPS ONLY) (SEE INSTR.)
1.04 INPATIENT REHABILITATION FACILITY LIP PAYMENTS
           (SEE INSTRUCTIONS)
    1.05 OUTLIER PAYMENTS
                                                                                                                      278,952
   1.06 TOTAL PPS PAYMENTS (SUM OF LINES 1.01, (1.02, 1.04 FOR COLUMNS 1 & 1.01), 1.05 AND 1.42)
                                                                                                                   6,464,657
    1.07 NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT
           (SEE INSTRUNCTIONS)
           INPATIENT PSYCHIATRIC FACILITY (IPF)
   1.08 NET FEDERAL IPF PPS PAYMENTS (EXCLUDING OUTLIER,
   ECT, STOP-LOSS, AND MEDICAL EDUCATION PAYMENTS)
1.09 NET IPF PPS OUTLIER PAYMENTS
    1.10 NET IPF PPS ECT PAYMENTS
   1.11 UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR LATEST COST REPORT FILED PRIOR TO NOVEMBER 15,
           2004 (SEE INSTRUCTIONS)
    1.12 NEW TEACHING PROGRAM ADJUSTMENT. (SEE
   INSTRUCTIONS)
1.13 CURRENT YEARS UNWEIGHTED FTE COUNT OF I&R OTHER
           THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING
   PROGRAM". (SEE INST.)
1.14 CURRENT YEARS UNWEIGHTED I&R FTE COUNT FOR
           RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW
   TEACHING PROGRAM". (SEE INST.)

1.15 INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)
    1.16 AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)
   1.17 MEDICAL EDUCATION ADJUSTMENT FACTOR \{((1 + (LINE 1.15/1.16)) | RAISED TO THE POWER OF .5150 - 1\}.
   1.18 MEDICAL EDUCATION ADJUSTMENT (LINE 1.08 MULTIPLIED BY LINE 1.17).
    1.19 ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1.08,
   1.09, 1.10 AND 1.18)
1.20 STOP LOSS PAYMENT FLOOR (LINE 1 x 70%)
   1.21 ADJUSTED NET PAYMENT FLOOR (LINE 1.20 x THE APPROPRIATE FEDERAL BLEND PERCENTAGE)
   1.22 STOP LOSS ADJUSTMENT (IF LINE 1.21 IS GREATER THAN LINE 1.19 ENTER THE AMOUNT ON LINE 1.21 LESS LINE
   1.19 OTHERWISE ENTER -0-)
1.23 TOTAL IPF PPS PAYMENTS (SUM OF LINES 1.01, 1.19
          AND 1.22)
           INPATIENT REHABILITATION FACILITY (IRF)
   1.35 UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR
          COST REPORT PERIODS ENDING ON/OR PRIOR TO NOVEMBER
            15, 2004. (SEE INST.)
    1.36 NEW TEACHING PROGRAM ADJUSTMENT. (SEE
          INSTRUCTIONS)
    1.37 CURRENT YEAR'S UNWEIGHTED FTE COUNT OF I&R OTHER
           THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING
   PROGRAM". (SEE INST.)
1.38 CURRENT YEAR'S UNWEIGHTED I&R FTE COUNT FOR
           RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW
   TEACHING PROGRAM". (SEE INST.)
1.39 INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL
   EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)
1.40 AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)
   1.41 MEDICAL EDUCATION ADJUSTMENT FACTOR {((1 + (LINE 1.39/1.40)) RAISED TO THE POWER OF .9012 - 1}.
1.42 MEDICAL EDUCATION ADJUSTMENT (LINE 1.02 MULTIPLIED
          BY LINE 1.41).
   2
           ORGAN ACQUISITION
           COST OF TEACHING PHYSICIANS
          SUBTOTAL (SEE INSTRUCTIONS)
PRIMARY PAYER PAYMENTS
                                                                                                                   6,464,657
          SUBTOTAL
                                                                                                                   6,464,657
          DEDUCTIBLES
                                                                                                                   14,080
6,450,577
          COTNSUBANCE
                                                                                                                      286,552
  10
                                                                                                                   6.164.025
  11 REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROF SERVS)
11.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)
11.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES
                                                                                                                      133,649
                                                                                                                       93,554
  12
          SUBTOTAL
                                                                                                                   6,257,579
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MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC.

IN LIEU OF FORM CMS-2552-96-E-3 (05/2007)

HEALTH FINANCIAL SYSTEMS

13 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS
13.01 OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)
14 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER
TERMINATION OR A DECREASE IN PROGRAM UTILIZATION

OTHER ADJUSTMENTS (SPECIFY)

6,257,579 6,164,025 93,554

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC. IN LIEU OF FORM CMS-2552-96-E-3 (05/2007)

I PROVIDER NO: I PERIOD: I PREPARED 11/17/2008

CALCULATION OF REIMBURSEMENT SETTLEMENT I 15-2018 I FROM 7/ 1/2007 I WORKSHEET E-3

COMPONENT NO: I TO 6/30/2008 I PART I

I 15-2018 I TO 6/30/2008 I FART I

PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS AND LTCH PPS AND IPF PPS HOSPITAL

- ENTER THE ORIGINAL OUTLIER AMOUNT FROM E-3, I LN 1.05 (IRF) 50 ENTER THE ORIGINAL OUTLIER AMOUNT FROM E-3,I LN 1.05 (IRF. OR 1.09 (IPF).

  ENTER THE OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)

  ENTER THE INTEREST RATE USED TO CALCULATE THE TIME VALUE

  OF MONEY. (SEE INSTRUCTIONS).

  ENTER THE TIME VALUE OF MONEY.
- 52
- 53

HEALTH FINANCIAL SYSTEMS

		GENERAL	SPECIFIC	ENDOWMENT	PLANT
		FUND	PURPOSE	FUND	FUND
	ASSETS		FUND		
		1	2	3	4
	CURRENT ASSETS				
1	CASH ON HAND AND IN BANKS	8,304,289			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	2,304,857			
5	OTHER RECEIVABLES				
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS	-160,000			
	RECEIVABLE				
7	INVENTORY	82,121			
8	PREPAID EXPENSES	29,791			
9	OTHER CURRENT ASSETS	-356,379			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	10,204,679			
	FIXED ASSETS				
12	LAND				
12.01					
13	LAND IMPROVEMENTS				
	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	43,737			
	LESS ACCUMULATED DEPRECIATION	-21,371			
15	LEASEHOLD IMPROVEMENTS	4,270			
	LESS ACCUMULATED DEPRECIATION	-2,847			
16	FIXED EQUIPMENT	470,816			
	LESS ACCUMULATED DEPRECIATION	-243,714			
17	AUTOMOBILES AND TRUCKS				
	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT				
	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	250,891			
	OTHER ASSETS				
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS				
26	TOTAL OTHER ASSETS				
27	TOTAL ASSETS	10,455,570			

HEALTH FINANCIAL SYSTEMS

		GENERAL FUND	SPECIFIC PURPOSE	ENDOWMENT FUND	PLANT FUND
	LIABILITIES AND FUND BALANCE		FUND		
		1	2	3	4
	CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE	98,890			
29	SALARIES, WAGES & FEES PAYABLE	238,183			
30	PAYROLL TAXES PAYABLE				
31	NOTES AND LOANS PAYABLE (SHORT TERM)				
32	DEFERRED INCOME				
33	ACCELERATED PAYMENTS				
34	DUE TO OTHER FUNDS				
35	OTHER CURRENT LIABILITIES	85,000			
36	TOTAL CURRENT LIABILITIES	422,073			
	LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE				
38	NOTES PAYABLE				
39	UNSECURED LOANS				
	LOANS PRIOR TO 7/1/66				
40.02					
41	OTHER LONG TERM LIABILITIES				
42	TOTAL LONG-TERM LIABILITIES				
43	TOTAL LIABILITIES	422,073			
	CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE	10,033,497			
15	SPECIFIC PURPOSE FUND				
46	DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47	DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
18	GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
19	PLANT FUND BALANCE-INVESTED IN PLANT				
50	PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT,				
	REPLACEMENT AND EXPANSION				
51	TOTAL FUND BALANCES	10,033,497			
52	TOTAL LIABILITIES AND FUND BALANCES	10,455,570			

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TAL, INC. IN LIEU OF FORM CMS-2552-96 (09/1996)

I PROVIDER NO: I PERIOD: I PREPARED 11/17/2008

I 15-2018 I FROM 7/ 1/2007 I WORKSHEET G-1

I TO 6/30/2008 I
  STATEMENT OF CHANGES IN FUND BALANCES
                                                      GENERAL FUND
                                                                                             SPECIFIC PURPOSE FUND
                                                       1
                                                                                                 3 4
 1
       FUND BALANCE AT BEGINNING
                                                                       8,952,379
       OF PERIOD
NET INCOME (LOSS)
                                                                      1,081,118
                                                                     10,033,497
        ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)
       TOTAL ADDITIONS
10
11
                                                                     10,033,497
       DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)
12
13
14
15
16
17
       TOTAL DEDUCTIONS
FUND BALANCE AT END OF
PERIOD PER BALANCE SHEET
18
19
                                                                    10,033,497
                                                      ENDOWMENT FUND
                                                                                                 PLANT FUND
 1
       FUND BALANCE AT BEGINNING
       OF PERIOD
NET INCOME (LOSS)
        ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)
 5
6
7
8
       TOTAL ADDITIONS
10
11
        SUBTOTAL
       DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)
12
13
14
15
16
17
       TOTAL DEDUCTIONS
FUND BALANCE AT END OF
PERIOD PER BALANCE SHEET
18
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MCRS/PC-WIN FOR OUR LADY OF PEACE HOSPITAL, INC.

2552-96 v1701.100

HEALTH FINANCIAL SYSTEMS

HEALT	H FINANCIAL SYSTEMS MCRS/PC-WIN FOR OUR LADY OF	I PROVIDE	R NO: I PERIOD: I	PREPARED 11/17/2008
	STATEMENT OF PATTERN REVENUES AND OFERATING EAFT	I 13-2010	I TO 6/30/2008 I	
	PART I - PATIENT REVENUES	5		
	REVENUE CENTER	INPATIENT OUTPATIEN	T TOTAL	
	GTVIDAY TVDATTVIT DOUBLY GADE GENVICOS	1 2	3	
1	GENERAL INPATIENT ROUTINE CARE SERVICES  00 HOSPITAL	11,817,318	11,817,318	
4	00 SWING BED - SNF	11,017,310	11,017,310	
5				
7	00 NURSING FACILITY			
9	00 TOTAL GENERAL INPATIENT ROUTINE CARE INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS	11,817,318	11,817,318	
15	00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16	00 TOTAL INPATIENT ROUTINE CARE SERVICE	11,817,318	11,817,318	
	00 ANCILLARY SERVICES	16,533,761	16,533,761	
	00 OUTPATIENT SERVICES			
	00 00 TOTAL PATIENT REVENUES	28,351,079	28,351,079	
	PART II-OPERA	ATING EXPENSES		
26	00 OPERATING EXPENSES	10,233,	619	
	DD (SPECIFY)	,,		
27	00			
	00			
	00			
	00			
	00 00			
	00 TOTAL ADDITIONS			
	EDUCT (SPECIFY)			
34	00			
	00			
	00			
	00 00			
38	00 TOTAL DEDUCTIONS			
	00 TOTAL OPERATING EXPENSES	10,233,	619	

HEALTH FINANCIAL SYSTEMS	MCRS/PC-WIN	FOR OUR	LADY OF	PEACE	HOSPITAL,	INC.	IN LIE	J OF F	ORM CMS-2552	-96	(09/1996)
					I	PROVIDER	NO:	I PER	RIOD:	I	PREPARED 11/17/2008
STATEMENT	OF REVENUES A	AND EXPENS	ES		I	15-2018		I FRO	M 7/ 1/2007	I	WORKSHEET G-3
					I			I TO	6/30/2008	I	

## DESCRIPTION

1	TOTAL PATIENT REVENUES	28,351,079
2	LESS: ALLOWANCES AND DISCOUNTS ON	16,663,724
3	NET PATIENT REVENUES	11,687,355
4	LESS: TOTAL OPERATING EXPENSES	10,233,619
5	NET INCOME FROM SERVICE TO PATIENT	1,453,736
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
	PARKING LOT RECEIPTS	
	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	1,877
23	GOVERNMENTAL APPROPRIATIONS	
24		3,277
25	TOTAL OTHER INCOME	5,154
26	TOTAL	1,458,890
	OTHER EXPENSES	
27	LOSS ON INVESTMENTS	377,772
28		
29		.=
30	TOTAL OTHER EXPENSES	377,772
31	NET INCOME (OR LOSS) FOR THE PERIO	1,081,118

<sup>\*\*\*</sup>FINGERPRINT Line 1 tpubWFB3pME:7BtMVJqo0mNVhbpuW0
\*\*\*FINGERPRINT Line 2 TB9Im0gCKjxebuxHUGuunyXDASKrX8
\*\*\*FINGERPRINT Line 3 7r8154XiQz0Ct5In